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MEDICARE PAYMENT POLICIES

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BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JULY 19 AND 20, 1995

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MEDICARE PAYMENT POLICIES

WEDNESDAY, JULY 19, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Grassley, Simpson, Moynihan, and Graham.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order. If the witnesses want to come forward and take their places at the table. Bring Dr. Colby and Dr. Young with you. We welcome Gail Wilensky back again. She was just here last week and I told her that I hoped she would not get any questions on colds.

Senator MOYNIHAN. She got to the beach, though. I can see that.

The CHAIRMAN. This is another in a continuing series of hearings on Medicare. And, as the witnesses are well aware, the Finance Committee has its work cut out for it. We have been ordered to attempt to restrain spending to about 7 percent instead of 10 or 11 percent, and try to save $270 billion over 7 years.

We also know that Medicare is not on the verge of bankruptcy, but for all practical purposes is bankrupt. I am hoping the witnesses today, in a brief period of time, can tell us exactly how to come up with the savings that we need in a manner that will be bipartisan and uniformly accepted by all groups concerned.

I want to also say to both Dr. Altman and Gail Wilensky, thank you very much for the work that your staffs and your respective groups have done. They have been sensational in working with our staff and I appreciate it very, very much.

Senator Moynihan?

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Thank you, Mr. Chairman. Welcome, of course, to our distinguished witnesses. What I have to say now does not apply to them in the least.

Just as a matter of maintaining our standards in this committee, on May 17th Dr. Nancy Dickey appeared before us representing the American Medical Association and she testified in writing that "physicians now spend over 25 percent of their time processing

paper work and complying with the technical requirements of an unending blizzard of Medicare regulations."

We wrote to her to ask the statistical or analytic basis for that finding, and there was none. I do not think people should come before this committee and make statements that they cannot substantiate.

I have written a letter, Mr. Chairman, to Dr. Dickey expressing our disappointment. With your permission, I would like to have it placed in the record.

The CHAIRMAN. Without objection.

Senator MOYNIHAN. Thank you, sir.

[The letter follows:]

Daniel Patrick Moynihan
New York

United States Senate
Washington, D.C.

July 13, 1995

Dear Dr. Dickey:

In the course of your testimony before the Senate Committee on Finance you were asked to provide data substantiating your claim that "physicians now spend over 25 percent of their time processing paperwork and complying with the technical requirements of an unending blizzard of Medicare regulations." Your response was that although you did not have the information with you, it did exist and you would be more than willing to provide it.

What was received constituted a collection of irrelevant anecdotes accompanied by data which not only failed to substantiated your testimony, but was in fact wholly contradictory.

Beyond the irrelevant, your letter attempted to restate the question. And while the assertion that: **"It is no exaggeration to say that a quarter of the time I spend serving Medicare patients is consumed by personal administrative responsibilities,"** (your emphasis) may be true, it was made abundantly clear that your testimony and the data requested was to the experience of <u>all</u> physicians.

Testimony before the Senate Committee on Finance is carefully considered with particular attention to research and data. Mistakes are acceptable, efforts to mislead are not. Members of this Committee rely on such testimony in the formulation of public policy; this cannot be based on the experience of one doctor when there are more than half a million nationwide. You were asked for <u>data</u>, you responded with anecdotes.

Even the anecdotes themselves are highly suspect. No distinction is made between unnecessary Medicare administrative costs and administrative costs associated with quality patient care. For example, you state that you spend "five

minutes of 'chart time' for every 15-20 minutes spent with a Medicare patient." A complete patient chart, however, is an integral part of quality patient care. Do you regard recording a patient's temperature as a needless demand of the Medicare bureaucracy?

In addition, the only data you did provide, generated from the 1993 AMA survey of physicians, demonstrates that only 5% of the time spent by those physicians surveyed was consumed with utilization review, claims, and billing. The Senate Finance Committee is debating the future of Medicare; different parties may disagree on the most appropriate actions, but we must come to some agreement on the facts of the current situation. For this rigorous research is demanded. Your testimony did not meet this standard.

Failure to submit data supporting your claim, leads to the conclusion, with some reluctance, that the Committee was misled. If any data corroborating your testimony does exist, please send it immediately.

Sincerely,

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I do not have a formal opening statement, but I do look forward to hearing from the panel today. I am going to be particularly interested in issues relating to payments under managed care arrangements. I am very concerned at the current provision of 95 percent reimbursement standard.

I would be interested in your recommendations of what you think are going to be the practicalities of altering our managed care arrangements, how expeditiously can they be put in place, and what effect might they have in terms of achieving the budget marks that have been set for this committee within the Medicare program. Thank you.

The CHAIRMAN. The two groups that Dr. Altman and Gail Wilensky represent, the Prospective Payment Assessment Commission for Dr. Altman, and the Physician Payment Review Commission for Gail Wilensky, probably have had more to do with advising us about Medicare expenses—one in hospitals and hospital-related, the other in physicians and physician-related—than any other two people or two groups in the last decade. So we look forward very much to what you have to tell us today, and we will start with Dr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, WALTHAM, MA, ACCOMPANIED BY DONALD YOUNG, EXECUTIVE DIRECTOR, ProPAC

Dr. ALTMAN. Well, thank you, Mr. Chairman. It is a pleasure to be here. Both Senators and I go way back. It is always a pleasure to be here.

In the 10 minutes that are allocated, I just want to summarize a few things. My testimony is quite detailed and I am sure it will be in the record, and I know your staff and our staff have been working on it quite intensely.

Let me make a few over-arching comments. We have been trying to look through our bag of areas that we focus on to understand where cuts can be made that do not do irreparable harm to the health care system and to the beneficiaries.

In the areas that we have focused on in our responsibility, Part A, for the most part, I would like to make a few comments. With respect to hospitals, it is possible for the government to do a better job of bringing its payment down much closer to the success of hospitals in controlling costs.

I think we have gone through a very historic period in the last 2 years where hospitals—they should get a lot of credit for this—have been able to bring their costs down to below inflation for the first time in my memory, and in the last 2 years cost increases have been running, in real terms, at negative one and 2 percent.

The Medicare program, however, because of legislation, has not completely taken account of that. And, as a result, hospitals which had been losing significant amounts of money under Medicare PPS, on average, now are earning profits which in other circumstances would be fine, but, given our current budget situation, I think the program could bring those rates down.

The CHAIRMAN. Say that again. On average, the hospitals are now making money on Medicare?

Dr. ALTMAN. Yes. We estimate for 1994 that hospitals will be earning about 2.3 percent profits on PPS, where two, three years ago they were losing, on average, 2 percent.

Senator MOYNIHAN. Medicare profits?

Dr. ALTMAN. On Medicare. And they are earning significantly more overall. It is the PPS part. But, for the private side, overall, their profits are closer to about 4.5 to 5 percent. So, we can bring that down.

Now, one group of hospitals, which I know well and I know Senator Moynihan knows well, are teaching hospitals. They make the largest profits on Medicare. Their profit rate, on average, was close to 12 percent.

The reasons are fairly clear, and that is that Medicare has been providing teaching hospitals with added payments, both for teaching and for disproportionate share and, as a result, their profits on Medicare PPS are quite sizeable.

But I should also point out that when you look at teaching hospitals as a whole, their overall profits are among the lowest, so that while fairness would dictate that teaching hospitals do take a reduction in their payments from Medicare to bring their payments more in line with their costs, we need to be very careful about our

teaching institutions if we want to preserve them as the quality institutions they are.

Therefore, while we have recommended at ProPAC that we bring the teaching adjustment down by 13 percent next year and up to 40 percent over 3 years, my fellow commissioners want to emphasize that we think you should be very careful.

I would even suggest that you set up maybe some informal monitoring group to make sure that we do not do serious harm to them, but we do need to bring the Medicare payments more in line, I think, with the costs.

We are particularly concerned if you add up all of the cuts and they hit the same hospitals, if you are talking about teaching cuts, disproportionate share cuts, and overall, that we make sure that we target the limited funds that are left to the hospitals we really want to protect. We are working with your staff to try to do that.

A few other areas are particularly troublesome. While we have maintained a good degree of control over both hospitals' payments under Medicare, and Gail is going to talk about physician payments, the two areas of the biggest growth over the last half a dozen years have been home health care and skilled nursing care.

Now, there are some very good reasons and some very positive reasons for that growth because we have learned how to provide care in the home where before it had to be done in the hospital and you can save money doing that. We also are keeping people out of the hospital. That is also a good thing. But the growth rates are far in excess of what we would have expected from those savings.

Unfortunately, one of the reasons is that, while we have all these nice, fancy controls, on hospital side and on the physician side, both skilled nursing facilities and home health, essentially, are in the old mode; they are cost-based, there are no deductibles and coinsurance in home care, and they have just grown by topsy 40 and 50 percent a year. If you add up over a 10-year period, they have grown by 3.5 times in skilled nursing care.

So we have made several recommendations in our testimony to deal with that and I will be glad, in questions, to go through it in more detail.

Now, I want to focus just very briefly on managed care. I know Gail is going to be talking about that at some length and we sort of share this thing. I do not want to take all of her thunder. But let me make it very clear. We strongly support the movement of many more seniors into managed care, but we have to understand something.

If the Medicare program is to achieve the savings that you need, some very tough choices have to be made. One, in certain parts of the country, beneficiaries that go into managed care get very sizeable extra benefits —I am talking about $140 a month—$140 a month—in extra benefits—because they go into managed care, where in other areas, like Oregon, when they go into managed care they get very little extra benefits.

So Medicare, which always prided itself on having comparable benefits around the country, you cannot say that anymore. If you sign up for managed care in southern Florida and in southern California, you wind up, as a beneficiary, getting sizeable extra benefits, and that is the way the program was set up. I do not have any

objection to that in and of itself, but you cannot do that and still expect the savings.

So if you are going to get the savings out of managed care, that 95 percent rule currently works to hurt the program. It helps the beneficiaries and it helps the plans, but it does not save money for the program. If you are going to get those savings you are going to have to reduce those benefits.

On the other side, if you start reducing those benefits and do nothing with the fee-for-service side——

The CHAIRMAN. Let me ask you a question. Any of us can interrupt if we want since there is just the two of you here.

Do you mean, you take a State like Oregon where the costs are so low, the 95 percent is a low enough payment that the providers cannot afford to give many more than just the basic Medicare services.

Dr. ALTMAN. Exactly.

The CHAIRMAN. You go to a high-cost State and go to managed care, managed care can significantly cut their cost and give the benefits.

Dr. ALTMAN. Exactly.

The CHAIRMAN. All right.

Dr. ALTMAN. That is exactly what it is. And the payment rate, even though it costs more in those areas, is even higher than the costs would justify. And HCFA knows it, but, by legislation, they cannot change it, which means if you lower it, then the plans are going to be forced to cut back.

Now, if you do that, you could wind up making things worse for managed care than they are today, so you need to be very careful. In our view, the only way to balance that equation is to say to beneficiaries, if you stay in fee-for-service you are going to have to pay something in addition for the high costs, or you could wind up with less people in managed care 5 years from now than you have today.

My testimony covers a number of other areas in out-patient care, capital payments, and so on, but those are the three points I wanted to make. Yes, we can cut hospital payment increases, but we need to be careful about not hitting the same hospital every time; two, we need to sort of do something in the skilled nursing facilities and home health, and I have a number of suggestions there; three, we should move more seniors into managed care, but we do need to change that managed care structure if we expect to see significant savings.

The CHAIRMAN. When you say hitting the hospitals at the same time, you mean, you take a great teaching hospital that is also in an urban center that has a disproportionate share, and if we did nothing but apply cuts uniformly, but it happened to hit three or four of their programs, we could absolutely devastate them.

Dr. ALTMAN. Yes. And then if you realize that it is those institutions that really rely on Medicare and Medicaid. Other institutions could take the cuts because most of their patients are in the private sector and they get plenty of money from them, although they are having their own problems with tough managed care, as they should. But, if you hit a hospital which has 50 percent Medicare

and Medicaid and 10–20 percent bad debts and you hit them three times, you are going to find a hospital really in serious problem.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Altman appears in the appendix.]

The CHAIRMAN. Gail?

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, WASHINGTON, DC, ACCOMPANIED BY DAVID COLBY, PRINCIPAL POLICY ANALYST, PPRC

Dr. WILENSKY. Thank you. Mr. Chairman, I am going to follow Stuart Altman's role and try to summarize the main points that I would like you to take away from the testimony. As you know, there are a lot of technical issues that are in this testimony. I would be glad to respond to them. The PPRC staff has been working with your staff to make sure that they understand the technical issues.

Let me try to answer your direct question to us, which is, how can the Congress go about trying to achieve the substantial savings that are set before it? This is not part of my testimony and, therefore, it is not really my role as PPRC Chair, but I want to try to answer it.

I believe it will take a combination that will build on traditional ways that the Congress has found to secure savings from Medicare. That means going after hospital payments, going after home care, either in co-pays or some bundling, skilled nursing home, physician payment, either through the conversion factor or some other mechanism, also, the other parts of Part B that I would like to touch on in my testimony, looking to the beneficiaries, the elderly as well, in terms of possible premium payment increases or some deductible, the kinds of mechanisms that the Congress has used in the past.

I think you need that because it will provide savings with some certainty. It can start the savings ball rolling and give you a number of years to accumulate those savings, but I also want to say very strongly that I believe those kinds of changes alone will not make Medicare sustainable in the long run, nor will they provide you with the long-term savings that you need. You must also redesign the basic incentives of the program.

Right now, there are not incentives in place. I am going to touch on them—Stuart has already touched on some of them. Current policy does not reward the elderly for seeking cost-effective health care plans and cost-effective providers, and does not give the elderly very many options or very much information on which to base their choices.

Unless there is that fundamental restructuring which can also give you savings—although, in all honesty, it will probably take a few years until you begin to see those savings—I believe you will not accomplish long-term goals. So, I think you need to look to the traditional ways of having savings. The commissions, CBO, and your staff are working hard to give you options, but I want to emphasize the issue about long-term restructuring.

Let me talk a minute about the fee-for-service part of Medicare because, while all of us have been looking to a restructured Medicare program that will offer many more options and that will probably, therefore, increase the enrollment in managed care, the fact of the matter is, over 90 percent of the elderly are now in fee-for-service medicine, so we cannot just ignore it.

There are some technical problems that need to get fixed with regard to fee-for-service medicine. One of them has to do with the spending goal. As you may recall, in 1989 when you passed the legislation creating the resource-based relative scale, there were really two parts to it.

One, was to try to set a fee schedule in a different manner, rather than having it just be what turns out from the insurance world, to try to rationalize the differences between what specialists were paid and what primary care physicians were paid.

I have personally had some qualms about the notion of government trying to set 9,000 prices, but, having engaged in that activity, there was the rationale of trying to take extreme values, and particularly the distortion, that encouraged procedures relative to primary care and to get them in better order and also to try to reduce the very large differences between urban and rural payments, far greater than any cost-of-living measure would have justified.

In addition to trying to rationalize the fee structure, it was also an attempt to try to moderate spending by linking the increases in that fee structure to how well physicians did in terms of meeting spending goals. That spending goal has a complicated name called the Volume Performance Standard.

What has happened is that some problems have developed, some which people saw early on, some of which got introduced in legislation later, that really need to get fixed.

One of them is that we use different updates for three different groups of services: for surgical, for primary care, and then for the rest.

And, while there is some justification for trying to disaggregate spending goals and increases in fees for different services, you would have to do it far more disaggregated if you were really to try to do it as a direct incentive to practice more conservative medicine.

What has happened in the present world is that the attempt to try to redirect money toward primary care services is getting undone because it turns out that surgical spending has been lower and therefore increases in surgical fees have been substantially greater than for other services.

So, while that is what Congress said the rules of the game would be, you are undoing the fundamental rationale for trying to reprice these 9,000 services.

The commission has proposed going to a single standard and a single update. I do not want to say it is entirely equitable, but, on balance, it will continue what I gather was your very strong interest in trying to increase payments to primary care physicians.

In addition, there have been some problems with the spending goal. Because there was a concern that there were a lot of inefficiencies in medical care, Congress legislated that the standards ought to be decreased to make up for these inefficiencies.

In 1993, the deduction from the standard got up to four percentage points, and that is a rather unreasonable built-in factor into the spending goal. No matter what physicians do, if they do not do at least four percentage points better than their previous performance, it impacts their updates.

The commission has suggested substituting the growth of Gross Domestic Product and maybe making little allowances for increasing technology and using that rather than this complicated spending goal, less four percentage points. So there are some technical issues, but as long as we are 90 percent fee-for-service we really need to do some of these fixes. So, I want to encourage that the PPRC staff and commissioners work with the Congress to try to fix those particular problems.

Let me talk for a minute, though, about the rest of Part B. This is an area that is not directly under the charge of PPRC, but it is not under the charge of anyone else so it tends to get ignored.

Like the fact that home care and skilled nursing have grown so much faster than hospitals, the fact is, the other non-physician component of Part B has been growing and is continuing to grow much faster than the physician part and it represents 49 percent of Part B spending. That is, out-patient hospital charges, clinical labs, durable medical equipment. All of those ought to be regarded as important areas to look for savings.

Again, these are areas where the commission or your staffs can give you some guidance. But, because you tend not to hear about those areas from us so much, please do not ignore them, they are important.

Let me talk for a minute about graduate medical education and then I want to finish with a couple of comments on managed care.

Stuart made some comments about how some hospitals may be hit in multiple ways, depending on the kinds of reductions that occur, and I agree with that. I want to encourage you to consider that.

I hope, if not this year, sometime soon, however, that the Congress will look at the more fundamental question about exactly what is the appropriate role of government in graduate medical education, not just whether the numbers for direct and indirect medical education are the right numbers to reimburse for costs. That is important, and you have had recommendations from both of our commissions about that.

But I think it is important to look at the bigger question which is, exactly what is the role? Why is there a role for graduate medical education when the Federal Government typically does not have roles for graduate engineers or bench scientists, or other areas? It is an issue that we are going to spend some time looking at at PPRC, and it is an issue I encourage you to consider as well.

Finally, a few minutes about managed care. Many of us think that managed care provides important ways for seniors to get more benefits for a given amount of money and is the direction that the private sector is going, and that, just as Medicare was made to look like the private sector of the 1960's, it seems important to incorporate the kinds of changes and innovations that are going on now.

There are a number of problems with the payment mechanism that is used, the so-called AAPCC. Part of it has to do with the vol-

atility in terms of 1 year to the next, part of it has to do with the variation in terms of being in one county versus another county.

The reason is, it keys off the average spending in the county in which somebody lives and if the average spending is different substantially in the next county, even though people may cross county borders, it has a very big impact and that has led people to suggest using a little bigger geographic area.

Now, Stuart raised an issue that had to do with the fact that there is a lot of unfairness because of the different value of benefits. I think it is unfair. I actually do not think it impacts the savings to the government, but I think it is fundamentally unfair. But it raises an issue that I think you are going to have to deal with, and this has to do with competitive bidding.

A lot of people, and myself in the past, have talked about competitive bidding as a way to get a better pricing. But, if we do not use the competitive bid price for the fee-for-service physicians and hospitals in that area as well, we do not have the same price going to both sides, and we will put, potentially, the managed care plans at a competitive disadvantage.

So, while I think it is important to figure out a way to get better pricing to get around some of the problems, I want to urge a little caution in something that has been raised frequently as the wave of the future, competitive bid.

Competitive and negotiated bids are just fine. The fixed price, the price the government pays, needs to be the same for fee-for-service as for managed care or you will, in fact, widen the discrepancy between those two. So, I would urge you to look forward to that as a strategy with some caution if you cannot make a fixed payment in both areas.

We have outlined a number of areas that we will be working on in the future in order to try to help the Congress, and look forward to those activities.

Thank you.

The CHAIRMAN. Let me ask both of you. Paul Ellwood thinks that if we go to managed care you are going to go to national managed care; you will not have to worry too much after four or 5 years about geographic differences, that if Oregon happens to be $3,300 Medicare cost year and Louisiana $5,500, that you are going to have companies bidding in Louisiana and willing to provide care for $3,500 or $3,600. Do you think his theory is right, that you will have this National leveling out?

Dr. WILENSKY. Well, I think you will have some, but, in fact, if you look at how medicine is practiced around the country, there really are some significant differences in practice style.

The CHAIRMAN. Practice style?

Dr. WILENSKY. Style. In the amount of technology and the level at which procedures are used and the mix between in-patient and out-patient.

So, while I think that there will be less of a difference than we now have, part of that is something that the government can determine if it wants to. The way you would do that is, if you started on a national average as a per capita payment and only made adjustments for cost of living, you would force practice styles to converge toward some average level.

This is a big issue in Florida. Florida is a high-cost area. Part of the reason that the Florida average payment is high is that costs in Florida and New York are higher than a lot of other places, but, frankly, they are also high-volume areas and the average payment now represents both an increase in price and the increase in volume.

Whether or not you want to try to negotiate a bid in the local market and accept some differences or whether you literally want to drive to a national average is a serious issue and it is a policy issue, it is not just a budget issue. Because you can get your savings either way, there is also some fairness involved.

The CHAIRMAN. Dr. Altman?

Dr. ALTMAN. Let me support what Gail said. I am surprised that Paul said that, knowing what he does know about differences in the costs, not only in the Medicare program, but if you go into the under 65 population and you look at large corporations—I have spent a lot of time with large corporations—they pay different amounts for essentially the same kinds of individuals in different parts of the country. They would like to standardize it.

And it is true that when you go to the under 65 population the differences are not as great as Medicare, so they will be reduced, but they will not be eliminated as long as physicians not only practice differently, but have different resources at their fingertips, the ability to do testing, more nurses per patient, and so on.

So I do not think we are going to go to national rates. You have to watch out. You could wind up going to national rates where the national rates get kicked up to the high-cost areas, not to the low-cost.

So I think Gail and I share the same feelings, that unless we change the practice of medicine fundamentally in high-cost areas overnight, we are not going to see that happen very quickly.

The CHAIRMAN. Dr. Altman, you mentioned moving to prospective payment for home care.

Dr. ALTMAN. Yes.

The CHAIRMAN. Can you expand a little bit as to how you think we can do it, and what kind of savings we can get?

Dr. ALTMAN. Well, there are several parts of the home care issue that are troubling to me. The first, is that as you know, home care now requires no co-insurance. It was based originally on the idea that individuals would leave the hospital having had a three-day stay and already paid the deductible, but now many people go to home care without ever having been to the hospital.

So one possibility is to introduce a co-insurance rate only for individuals who have not been hospitalized and to limit the maximum to the same deductible that they paid if they went in the hospital.

This way you could not hit an individual too hard but still get some savings, even though it is not likely to impact on utilization that much because most of that would be paid for by some insurance policy, but there would be savings to the government.

But this basic change that is being discussed where you would begin to provide incentives to the agencies to limit, hopefully in appropriate ways, the use of services is very attractive and it is being proposed by the industry.

We have some problems with it, especially limiting too many new people from coming on, but we are encouraged by that kind of a proposal where you essentially establish prospective rates and prospective budgets. Don Young has been working with Julie and Susan to make something like that work, both consistent with the industry and with helping the government.

The CHAIRMAN. Do you want to comment, Gail?

Dr. WILENSKY. I very much like the idea of prospective payment, of bundling of the payment. There are occasionally people who have suggested putting that into the DRG payment for hospitals, which I think is not a good idea. I think you ought not to leave this as a monopoly to the hospitals, but having the bundled payment so that you put this together is one that I think that you ought to pursue.

The real question is, can you do it fast enough? If you cannot do it right away it is an area that ought to be looked to for savings. There has been huge growth in the number of people served and a 50 percent increase in the number of services per person served, so both of those have grown.

I think that co-insurance is a reasonable way to go. I think I would probably consider a co-insurance, maybe a step-down co-insurance, if it was following a hospital stay, but, given the huge volume increases, I think that we have just got to do that.

Hopefully it will encourage some people to give, again, another look at managed care as a way to not have to pay the co-insurance, since that is frequently a part of the package of benefits, not forcing people into managed care, but giving them one more reason to consider it.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Thank heaven we have these two so we can cope with this.

I just would make one comment and then ask one question. Stuart, we keep hearing that prices seem to be coming under control. Last year was a long exercise in the assumption that prices were out of control, but they seem not to be. Out at Jackson Hole they indicated that managed care premiums were down somewhere around 1 percent this year. Your data shows that real hospital costs grew at 1.7 percent. GDP growth is higher than that, right?

Dr. ALTMAN. Yes. Right.

Senator MOYNIHAN. So that is not an unstable situation, is it?

Dr. ALTMAN. Well, let me comment on hospitals, first. Hospitals, over the last 2 years, have really taken a very hard look at their costs in ways that they have never done before.

It has led to tougher wage adjustments, it has led to cuts in employees, unfortunately, but they are bringing their costs under control and they are doing it, for the most part, because of the pressure of the market. It has not been the government squeeze, it has been the market pressures of the managed care companies and others, both reducing patients——

Senator MOYNIHAN. That is what we were told to expect by Dr. Ellwood.

Dr. ALTMAN. Well, I think Paul and the Jackson Hole group were right in that sense. But let me just put a cautionary note out there. Just because costs are coming down, prices have not come down as

much. We need to see more competition and we are beginning to in the managed care area.

Now, that is the way markets work. The first group of managed care companies go in, reduce the costs, get the savings from the specialists in the hospitals and, unfortunately, do not pass all of it on to lower prices in premiums because they have mined it, first.

Senator MOYNIHAN. Do they make profits?

Dr. ALTMAN. Yes, I think we could say that. But, given markets, they ultimately have to pay the market price, too, and then other managed care companies start coming in and squeezing down those profits. So I expect that in the next round you will see more of those cost savings reflected in lower premiums.

Dr. WILENSKY. But that is the private sector. I mean, the fact is, the incentives of aggressive purchasing in the private sector do not exist in the public sector. The public sector basically works under direct control. This is direct command and control.

In physicians, it is the relative value scale and the spending goals and in the hospitals it is the DRGs, and in the clinical labs, skilled nursing, home care, durable medical equipment and out-patient, it is not much of anything.

Senator MOYNIHAN. But that is obviously the problem.

Dr. WILENSKY. We should not be too optimistic about Medicare, although the parts we are direct-controlling are doing better than the parts that are not direct-control, but neither of them are doing nearly as well, we think, as a result of the aggressive purchasing in the market.

Unless we do something to change the incentives that the elderly face to drive those same kinds of changes, to capture some of those same kinds of changes, we should not expect they are just going to fall into our lap.

Senator MOYNIHAN. Well, the teaching hospitals really do have me concerned. We had a hearing last year. I think you remember this, Mr. Chairman. A physician from Fordham testified that, we are seeing the commodification of medicine.

He gave us an example. In Southern California we now have a spot market for bone marrow transplants. And now you pick up the papers and find that Los Angeles County General Hospital may close. This is one of the unanticipated consequences of a more efficient pricing, is it not?

Dr. ALTMAN. I think that there are some very positive things we have talked about and there are some unfortunate areas. I think we need to be very concerned about our health care safety net.

Senator MOYNIHAN. And our medical schools.

Dr. ALTMAN. Well, yes. Some of the medical schools also are health care safety nets. Some of the medical schools are doing very well, thank you.

Senator MOYNIHAN. You mean, Columbia-Presbyterian, which is in New York. It has such a high level of Medicaid and Medicare because of the neighborhood in which it is located.

Dr. ALTMAN. That is exactly right.

Senator MOYNIHAN. Neighborhoods happen to be that way, yes.

Dr. ALTMAN. Not all the teaching hospitals in New York are like Columbia Presbyterian.

Senator MOYNIHAN. Right. We have got to watch that, Mr. Chairman. I know we will. Thank you.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to ask questions in two areas. First, in the area of managed care. Dr. Wilensky, you raised some questions about the implications of trying to go to competitive bids as a means of selecting HMO providers for intermediaries. That is a process that has been used in the private sector and in some non-Federal Governmental programs.

Do you believe that is inherently inappropriate for Medicare, or could it be rendered appropriate with some safeguards? If so, what are those safeguards?

Dr. WILENSKY. I think it is a fine process. It may work better in terms of a mix between a negotiated and a competitive bid. That is, you sort of look and you peek and you jawbone to try to get better bids.

The issue I am concerned about is that if we only do it in managed care and we do not do the same premium equivalent for the fee-for-service, that you will put the managed care at a disadvantage.

And, since it is likely to happen first in the areas in which there are a number of managed care plans, we will take the very areas that are having a lot of managed care, for whatever reasons—in Florida's case because it is a high-priced area, or in Oregon's case, because there are a lot of them around for the under-65 population—and we run the risk of killing off that part of the Medicare market.

So my caution has to do with whether or not whatever the competitive or negotiated bid at a capitated level is for managed care, you have to turn around and arrange that the payments for fee-for-service in that area, when you combine deductibles, co-pays, and premiums, is the same payment. If you do not do that, then you are going to disadvantage managed care.

So if you think about it, think about the FEHB program, or the CALPERS, the program in the State of California, where there is a little jawbone, you go out and you do some negotiations on what the premium is. The idea is having the Federal Government pay its fixed dollar amount, even though some plans may be more expensive than others. It should not be the Federal dollar that increases if people take a more expensive plan, it should be what they pay as the residual.

So I think competitive or negotiated bids are a good idea. I worry, if they are not applied to classic Medicare, the now-dominant fee-for-service world, that we will do a disservice to the very place that we think offers our solution. So that is my big caveat.

Senator GRAHAM. Maybe I can ask my second question under managed care and then both of you can comment on it, and also Dr. Altman, if you would like to comment on the first question. That is, we are marked to reduce Medicare spending by some $270 billion over the period of this Budget Resolution.

Many have pointed to managed care as being a major component of that savings. What do you believe are the reasonable levels of acceleration into managed care? You mentioned, Gail, that 90 per-

cent of the current Medicare beneficiaries are in fee-for-service. Five years from now, what, in your opinion, is a reasonable market share for managed care within Medicare and what kind of savings do you think that might make available?

Dr. WILENSKY. Well, I think at the outside, getting as high as 40–50 percent by the end of the decade is possible, but, frankly, it is not going to happen unless there are some financial encouragements or pressure to move it in that direction.

I want to be clear, I think that restructuring Medicare alone is not going to get anything like the kinds of savings that the Congress has set out for itself, that you are going to need the traditional—going after home care, skilled nursing, hospitals, physician, clinical labs, elderly as well—to start that, but that once you have that as a base, switching to managed care can get you, I do not know, maybe 20 percent of that, 25 percent of that.

The CHAIRMAN. How much?

Dr. WILENSKY. Twenty to twenty-five percent. But it will take time to restructure so that you have that dynamic working in your favor, and I would strongly encourage you to proceed with more certain savings up front.

Again, if you would only do provider fees and looking to the elderly to chip in more, you are not going to fundamentally change those dynamics in the long-term. So, in the long-term, the change in the managed care is the most important thing you do; in the short-term, it is not going to get you $270 billion, at least as I calculate it.

Dr. ALTMAN. I think, moving in that direction makes a lot of sense. It is hard to know what that number will be. 50 percent Medicare managed care enrollment ought to be thought of as a real outside shot and is a number which has absolutely no credence. But there is just no guidance here. I think a third is going to be a more realistic number by the end of this decade, and then move it——

The CHAIRMAN. A third out of managed care out of the $270 billion?

Dr. ALTMAN. No, not a third of the dollars, a third of the beneficiaries. You have got to be careful.

The CHAIRMAN. Oh, into managed care.

Dr. ALTMAN. Yes. And the reason why I say that is several. First of all are really senior citizens, those in their 80's and late 70's. It is hard for them to adjust to change and I think we ought to be realistic about that. We do not want to force them. They are nervous enough about life; my mother tells me that.

The other area is, we have to get capacity out there. It is not a problem in southern Florida and it is not a problem in southern California, and the number of managed care firms are growing like topsy in New York. But, once you get out into smaller towns and rural areas where a lot of our seniors are, it is going to take longer so we ought to be moving it.

But I want to really emphasize what Gail said at two levels. One, is you cannot get the savings if you do not change the program. Two, if you are not careful, we could have in Medicare managed care what we almost had in the HMO Act. I worked for President Nixon back in the 1970's. We passed the HMO Act in 1973 and we

almost killed the industry because we saddled the HMOs with so many extra responsibilities.

We gave them a few benefits and then we said, oh, by the way, you have to do this, this, this, and this, and passed the legislation. Then we woke up 1 day and we almost did not have an industry. So we need to be careful in encouraging HMOs. If we do not do what Gail said, we could wind up with less people in managed care and we definitely will not get the savings.

So, more than just encouragement and patting on the back is needed. Some of the changes are not going to be well-received, I am afraid to tell you. I mean, if you tell a Medicare beneficiary in southern Florida that, oh, by the way, all those free benefits that you were getting, we have now negotiated a rate which is a third lower and the plan says, well, we will provide them, but you have to pay a premium, I do not think they are going to be happy with that. Yet, if you do not do that, you are not going to get the savings.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I am going to ask Dr. Altman and Dr. Wilensky about the adjusted average per capita cost, not in the sense that we are forcing people into HMOs, but in the sense of using this as a basis for vouchers.

I presume, first of all, that the AAPCC levels for my counties in Iowa is going to be pretty low relative to those values in other parts of the country.

If we use these values for the Medicare voucher program then I think I am going to have a situation where I am going to have to tell Iowa's Medicare beneficiaries, when they realize what they get, that they are getting a lot less than the rest of the country. If we use this as a basis, are we going to then build into the new system what many in my State think is an unfair allocation?

Dr. ALTMAN. Yes, sir. That is why I think both of us are saying that if you go to negotiated and competitive bidding rates, you will see an adjustment that the high rates will come down and some of the lower rates will come up.

I do not think it will be completely flat where it will be the same, but the differentials will be less. But, as a result of that, the high areas of today, those plans will be forced to charge beneficiaries premiums for things they are now giving them for nothing.

Senator GRASSLEY. I assume that if this is a basis for our savings that comes through reconciliation, we can do this early in the process, right?

Dr. WILENSKY. You could if you wanted to move away from the use of fee-for-service spending as it exists in a county as the driver for Medicare payments to a different way of calculating it. And you could also have that be the payment that is made available for people through a voucher or through a choice, like a Federal Employees Benefit Plan, if you choose to do so.

It will, however, cause a lot of redistribution. Some of it, I think both of us agree, is appropriate. That is, the differentials that have existed across the country, in part because of pricing differences, cost of living, and in part because of the volume of health care services that has grown in certain parts of the country to be very high, have been greater than you could justify.

But I think we would both urge a note of caution that, as you attempt to try to make them more similar—not equal, but more similar—you are going to be causing a lot of movement of funds away from Mr. Moynihan's State, and Mr. Graham's State, and from other States. That balancing is a serious political issue.

Senator GRASSLEY. Well, can we not assume that there are higher costs in New York and Florida because maybe they are higher cost States in which to live and that some of that is reflected in the cost of delivery of health care, but whatever procedure you might want to reimburse the medical personnel for, that the value of their service should not be any higher in Miami than it should be in Iowa?

Dr. WILENSKY. To the first part of your question, yes. Some of the reason for differences in spending is cost of living differences, rent and salary levels, and other reasons. Part of it is that parts of the country are much more aggressive, the health care world is much more aggressive in what they do. Classic examples have been New Haven and Boston.

Senator GRASSLEY. Well, is that another way of saying over-utilization?

Dr. WILENSKY. Well, whether it is over or under, they are different styles of practicing medicine. The question is, do you want to press or force a common capitated amount, except for measurable cost of living differences? I think that most people think that the differences that now exist, like Florida's high-volume and high-cost that are so great relative to Iowa—or last week I was in Nebraska and it was the same—that it is much more than a cost of living.

The question is, if physicians and other health care practitioners in parts of the country do more, do more testing, is that something that you want to force out of the system completely or do you want to let how physicians practice have some variation around the country? I mean, that is a question that you have to answer.

Senator GRASSLEY. Well, obviously I do not think we want to dictate a rigid system of the practice of medicine. Obviously, we do not. But there is a lot of, what do doctors just know about what is being done someplace else.

In our own State, 10–15 years ago when we set up the Care Review Commission we found within our own State patient time spent in the hospital was a lot more in Davenport, Iowa than across the river in Moline, Illinois. Just within the center of the State of Iowa. A lot more time spent in hospitals in Des Moines, Iowa compared to Story County and Ames, Iowa, the county right north of there.

Dr. ALTMAN. That is right.

Senator GRASSLEY. Doctors did not know that until somebody told them. Why are your patients being kept in the hospital longer in Des Moines, Iowa than in Ames, Iowa, or Davenport?

Dr. WILENSKY. I think providing information is an important element, and Iowa happens to have been very active in this area. They have a very good commission.

Senator GRASSLEY. But we have changed the practice of medicine, not to the detriment of people in our State, but just because you tell doctors that it can be done differently.

Dr. ALTMAN. And more is not necessarily better, and often more is worse. So let us face it, spending more time in the hospital is not always a positive experience, and could lead to more medical conditions. So you are absolutely right, the ability to do that.

Senator GRASSLEY. And spending less money does not mean less quality care——

Dr. ALTMAN. No.

Senator GRASSLEY [continuing]. Lower quality care, right?

Dr. WILENSKY. Well, it can be either.

Dr. ALTMAN. That is right.

Dr. WILENSKY. It certainly does not necessarily mean less quality.

Dr. ALTMAN. We at ProPAC have recently completed a State-by-State analysis of resource use, taking out all inflation, and we ranked States in terms of the resources that that State uses to——

The CHAIRMAN. What do you mean, resource use?

Dr. ALTMAN. All of the people care, the technology, all of the costs, taking out all of the extra inflation. It is an attempt to get at real spending after you have taken account of the fact that some States have higher wages, and so on, to look at the services that are being provided to the beneficiaries, and we rank them from the most efficient, the lowest resource cost, to the highest. We found some very interesting and some very surprising results.

Just to give you a little tidbit of that, the most resource-efficient State just happens to be the State of Oregon. I do not know what you do there. I do not know, maybe it is the weather. But you do not use a lot of medical care. Actually, it just beat out Hawaii, which was number two.

At the other end of the spectrum, you would have expected—I am sorry Senator Moynihan is not here—the really high-resource States to be New York, California, Massachusetts. They were not. Our very high-resource States were in the South, Louisiana, Alabama, Mississippi, Florida. Then we had States in the middle. Actually, Iowa is number 15, so it is significantly on the top side in terms of efficiency. We will be glad to share this list with you.

One of the reasons that tends to correlate with this is the health status of the population. It is not only the physicians and the medical community that is more aggressive, it is also true that, even if you have adjusted for age and sex of the population, the amount of needs of the population seem to be different. Unfortunately, some States have lower health status people for the same age and sex composition than others. So, we will share this with you.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Thank you very much, Mr. Chairman. I admire what you do with regard to presenting these things before us in almost machine gun fashion, these various hearings. We all show up and at least we have a wonderful array of people who can share with us as to what we should do.

Senator Moynihan and Senator Packwood deserve our commendation, because we know we have to do things and we cannot just continue to do what we have done for 16 years here, and that is, just talk about it and say, well, we will get to it.

And we are goaded along by twin or triple forces, the Trustees' Report on Social Security, and those hearings have been fascinating to hear the trustees tell us what we have to believe, that Medicare will go broke in seven years.

We hear people come here on the Floor, talking about how hideous it is to allow the growth of Medicare to only go up 6.4 percent instead of 10.5. I guess they feel that we should let it go broke, which does not sound too smart to me, but that is the babble you hear around here.

Then when you get to issues of the American public understanding when they do not know a COLA from CPI, or inflation from CPI, or inflation from a COLA, it makes it a little more difficult for us. The media does not seem to get it all sorted out, either.

Then when you talk about Medicaid, we know there that the skill at gimmickry is in direct proportion to the amount of money in the pot, and that has proven to be a corollary of clear import.

So here we are now, faced with things we must do and that very few of understand, the things you mentioned, things we have not even talked about, labs, X-rays, durable goods, and hospitals.

I heard you mention hospitals, Dr. Altman. In fact, you stated in your testimony that the overall financial condition of the average hospital continues to be good, although many individual hospitals are experiencing "financial distress."

You said that they are doing things, but my experience is what the hospitals are really doing now is really muscling up. They really are whistling. They are frightened. They know that the good days are over and they are going to play tough this trip. That is what I see, real tough, with money, ads, and so on.

But what percentage of all the Nation's hospitals would you say are in the category of "financial distress?"

Dr. ALTMAN. I do not want to just mouth off some numbers. We have the distribution. I think it is like 10–15 percent that are in serious distress.

Dr. YOUNG. From the Medicare's point of view, about 50 percent of hospitals in most groups are losing money on their Medicare type of business, but, on their overall business, they are doing much better.

Now, when you look at those that are losing money on their overall business, they come in and out so that in one year you might have 5–10 percent that are losing money, but in the next year you have 5–10 percent that is not the same. So they have an ability to move in and out of financial distress by generating revenue from other sources.

Dr. ALTMAN. To be more accurate, we estimated, in 1993, about 24 percent of hospitals had negative total margins, not just Medicare. But, when you get to the serious financial, the numbers, as I said, go down close to 10–15 percent.

Senator SIMPSON. All right. That is helpful. I will come back to that, but I want to ask Gail a question, if I may.

Has the Physician Payment Review Commission taken a position on raising the Medicare eligibility to the age of 70? Do you think that is a strategy which should be at least examined to slow the growth in Medicare spending?

Dr. WILENSKY. I believe the commission has not taken a position. My personal view is that, at the least, we ought to bring Medicare into the same eligibility as Social Security.

I think that when we do that we need to think about whether or not we want to do something like also exists in Social Security, where you can start earlier, at 62, because there are some people in their early 60's who begin to show some signs of disability, but that the amount that Medicare pays would be a reduced level, very much like Social Security.

We are living longer. It is not clear that we are sicker in that early age of the mid-60's in the beginning of the Medicare period. We have to find ways to encourage people to keep working and not be in the pension and Medicare phase, for all sorts of reasons.

Senator SIMPSON. Well, Senator Kerrey and I, in a bipartisan way, are trying to determine ways to restore solvency to Social Security, and one of them is to phase up the eligibility to 70 over a long period of years and deal with payroll taxes, personal investment accounts, and CPI minus 0.5, and COLAS of realistic dimension.

Meanwhile, we leave off the table in this arena the one issue that is worth $360 billion a year. How absurd to be doing what we are doing and not talk about Social Security. $360 billion a year.

If we just toyed around the edges with it, COLAs, affluence testing, all the rest of it, we would not be in the anguish we are. We just sit, while it will go broke in the year 2031 and begin its decline in the year 2013, and we all know that, too. We are privy to a lot of information, but frozen in place.

Dr. ALTMAN. Just as Gail, the ProPAC has not looked at this. But I want to strongly support what you said, Senator. I think for many seniors, the thought of losing Medicare or significantly cutting back is more painful to them than some small reduction in Social Security. Health care is a very emotional issue; better balance between income and that important component is something to look at over time.

Senator SIMPSON. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Let me bounce a theory off of both of you. You have commented about Oregon and, indeed, by any standard, our stays in hospitals, our costs, are lower. We are low-cost. We also have a long history of managed care that came with World War II, and Kaiser, and big shipyards. At one stage during World War II, Kaiser employed 30 percent of the adult work force in the Portland metropolitan area and they were all covered by the Kaiser health plan, so people grew up with it. When the war ended, they kept it and went into selling it to everybody.

Oregon, or at least metropolitan Portland, has now, on a voluntary basis, passed 50 percent Medicare managed care. We have seven companies competing with each other selling different Medicare plans.

One of them does not provide prescription drugs, which I assume people buy if they do not think they need prescription drugs. They have a little choice. But the intriguing thing is how rapidly this is going to start to spread to the rest of the State, because you mentioned rural;.

Here is my theory. When we adopted the Oregon Medicaid plan we, in essence, are going to compel everybody in Medicaid to be in managed care, and they will all be there in a couple of years. Given that, the medical providers—the hospitals and the physicians—in the rural areas started to set up to handle Medicaid on a managed care basis. They had no choice. The normal carriers are bidding to carry the managed care business.

Basically, if you divide Oregon you have got a populated area, then you have got what we call the Cascade Mountains, and then Sierra Nevada, and California. Right on the eastern side of those mountains we still have a fair population. The town of Bend is what Denver was 100 years ago. But then you go east of that, it is wheat and cattle, six inches of rain, rural, rural.

But in this rural, rural part, between 1993 and 1994 we went from 0.1 percent managed care to 12 percent in one year. This is what Blue Cross/Blue Shield is writing of theirs. In the Bend area, from 2 percent to 25 percent. Just this one company in 1 year, Blue Cross/Blue Shield.

This was basically Medicaid coverage. They are starting now to write their Medicare managed care coverage in this area and the sign-ups are overwhelming. People are just voluntarily signing up in droves. I am curious, without any compulsion to sign up, they seem to be perfectly willing to do it.

Can this experience be replicated? I do not think this is unusual as to the health of our population or the climate, but they are voluntarily signing up.

Dr. ALTMAN. Well, managed care is a very positive concept for many seniors. We used to think that it was a negative and the only way you could get somebody into managed care was by essentially bribing them. That is true; we are all lethargic and we need momentum to change direction. But, once it changes, I think the same is happening in New York, I know it is happening in Massachusetts. I would support the idea that rural areas will not be without managed care.

I think it is going to be a different form of managed care and you will not have eight or nine plans competing against each other, but it can benefit from the kind of coordinated care that managed care provides. I do believe that there are savings, some of which should be passed on to beneficiaries in the form of other benefits or lower prices.

So I think Oregon is a very good example, but remember, you have had this long history. There is not a fear of this. It just takes awhile for people to get comfortable. I predict that New York is going to see—and is already seeing—major growth in managed care. We are seeing it in Massachusetts.

The CHAIRMAN. I was intrigued—then I will let Gail answer—when I was a young lawyer I did labor law for a large firm. I was low man on the totem pole in the labor law department. But, even then, in the late 1950's, major companies were signing up with Kaiser on managed care. All of the plans in those days allowed an opt out if you wanted to opt out. A monthly plan was maybe then $35–40, it was not the back-breaking expense that it is now.

What intrigued me was, first—and these would be plans of 4,000–5,000 people—Kaiser would bring the little mobile physical

exam van out to the plant and then sort of run employees through primitive physical exams, and they would catch a few things. Kaiser used to testify at the legislature that their hospital costs were not any cheaper, but they just did not hospitalize as many people.

The thing that intrigued me about the employees, with this voluntary opt out, 90–95 percent stayed with Kaiser. They did not seem upset. All this argument about, people are going to be mad if they cannot choose their own doctors. This was voluntary, people could opt out, and they stayed.

Now, I suppose, therefore, as those people got to 65 and became eligible for Medicare and they had had a lifetime of managed care experience, it was nothing to them to stay on in managed care experience. So you are right, we have a long history. Whether that can be replicated in 5 years in States that do not have that kind of history, I do not know.

Dr. WILENSKY. Well, I think you have raised a couple of issues that will be important as the rest of the country begins to follow suit. One of them, is the opt out issue. For many people, having it be their choice, even though they may never exercise it, is very important.

It happens that the largest growth in managed care is in networks that have opt out, and that some of the very traditional plans, like the Kaisers, are also sometimes including opt out provisions directly, although for a long time they did not.

I think this kind of a change, which will require some legislative change, will help seniors a lot, taking advantage of being in a network, getting a lower price, but if you want to opt out, knowing you can do so.

The other thing, when I was at HCFA, and since, I have tried to understand better about what goes on in rural areas. I have gone out with Members of Congress frequently to their rural areas or done speaking. I am surprised at the interesting variations that you see on managed care. Stuart said that it may not all be the same kind, and I think that is important to emphasize.

In some places it may be primary care case management. I was out in central Nebraska a week ago speaking at a rural referral center that is setting up linkages with eight hospitals that cover most of the rest of where they are to the western border at Colorado.

And, while they are not going at-risk yet, if their prices were a little higher in Medicare—the issue that Senator Grassley raised, if you did not level but made it a little more comparable—this was a group that was ready to go at-risk if, in fact, the financial strategy could be a little better.

So I think you will see Blue Cross/Blue Shield going in and recognizing a market, you see the Mayo Clinics going and trying to sign up primary care physicians in northern Iowa, you see the Loveless Clinic doing that in rural New Mexico, and you see some of these rural referral centers that already have these relationships that they have established with small hospitals, many of which are probably not going to sustain themselves in the future.

They are very small, they are low-occupancy, and 80 percent of what they have is Medicare. There is a good chance they are not going to continue in their present form, but if we have them as the

holding facilities—the essential Access, primary Access program started in Montana and is now in a number of other States, and there are linkages between these centers and rural referral centers—I think you will see a different kind of managed care, even in some of the rural and frontier-oriented places, it just will not look like what managed care looks like in Boston and New York City.

Senator MOYNIHAN. Mr. Chairman, I have to be on the Floor for the debate that is there now. I just want to thank our distinguished panelists, as well as Dr. Colby and Dr. Young. I am encouraged by what I hear. The end of the world may have to be postponed.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. I have done a couple of arithmetic calculations sitting here this morning.

The first, is that we have approximately 25 plus/minus working legislative days between now and when this committee has got to report its part of the Budget Resolution back to the Budget Committee.

The second arithmetic was a statement that Ms. Wilensky made that she felt that 20–25 percent of the $270 billion Medicare savings could be accomplished through a movement toward managed care.

If that statement is correct, the corollary is that 75–80 percent of the savings have to be accomplished someplace else, which means approximately $200 billion has to come out of the regular program.

She emphasized that it ought to be in areas where the savings were relatively assured, and listed some of those areas, many of which related to shifts in cost to the beneficiaries, in areas such as co-payments, deductibles, et cetera.

I think, Mr. Chairman, that what that says is we need to set for ourselves in this committee an aggressive schedule to get to the specifics of what it is going to take to find those $200 billion plus of cuts, and I would offer as my rationale, that some of the comments that Senator Simpson made about the importance of the elderly understanding what it is that is about to happen to them so that they do not feel as if they have been tricked or surprised by a last-minute proposal.

There also is going to be the importance of us spending some time on the avoidance of regressivity. The easy thing to do, for instance, is to treat every Medicare beneficiary alike.

For instance, I saw one proposal that called for raising the monthly premium for Part B up to almost $100 a month. That may be a fully acceptable thing for some Medicare beneficiaries who are relatively affluent, but it will have a very adverse effect on the large number of elderly who are at or below the poverty level.

There also is going to be the importance of the relationship, as you have cited, Mr. Chairman, between Medicare and Medicaid. In my State, the State pays a very substantial amount of those additional Medicare costs because it is the one that picks up the premium, the co-payments, the deductibles for that share of the Medicare population, which is also Medicaid-eligible.

So if we are going to be asking States to substantially increase their budgets to pick up higher premiums, we need to let them know as early as possible and let them be part of what we are going to do here.

Finally, we just had what seems like an unending debate on regulatory reform. I think one of the lessons that I have learned in this debate is that we are the culprit in many of the problems that we have under regulatory abuse because we did not do our craftsmanship very well. We passed laws that were ambiguous and left too much discretion.

The CHAIRMAN. We do it deliberately on occasion.

Senator GRAHAM. Sometimes, as in diplomacy, studied ambiguity is the way that you resolve tough problems. I do not think that this is an area that lends itself to ambiguity, either studied or otherwise, and that we ought to be as clear and precise as possible. That, again, requires time to be an effective legislative craftsman.

So my introductory statement, which may take up all the time for my question, is to encourage that we set a schedule of bringing forth the specifics of the Medicare legislation so that we will have more time in these remaining days to spend in fine tuning how we are going to find that $200 billion in cuts other than those that will be available through the movement towards managed care.

Having said that, Mr. Chairman, I would like to ask a question on the issue of Medicare fraud, which has been a long-time interest of mine. I was struck by another statistic of Ms. Wilensky, which is that 49 percent of the Part B payments go into areas other than physicians, and the areas that you ticked off—and the durable medical equipment particularly caught my attention—have been areas that have seemed to be particularly susceptible to fraudulent activity, defining fraud as either services or products billed but not paid for, over-billed, or inappropriately billed.

Do you have any suggestions of what we might do in order to ameliorate the level of fraud, particularly in the Part B area of the program?

Dr. WILENSKY. I think some of them are going on. I do think it is an area that, when you are so desperate for funds, you should not ignore. I want to say that I think home care now ranks right up there with durable medical equipment and clinical labs as areas of high fraud. It has been very rapid growth, and that seems to encourage some of the problems.

Going to a small number of payors, as has happened in durable medical equipment where you have now four regional payors instead of using all of the Part B payors, I think is a good move. It allows for somebody to monitor what is going on.

The kinds of changes that have started, but I do not know whether they have had any pay-off yet because it has been so early, is where you keep tabs by name and identification number of groups that are providing services.

One of the things that happens when you have very small mom-and-pop shops involved, as you have in durable medical equipment and as you have sometimes in home care, they come in and out of business.

Sometimes when you have had bad actors you do not realize the same bad actors pop up somewhere else because they will get a

new name, they will change one component of their name and go and have a different ID number. So keeping better track, which, in our computerized age ought not to be too difficult or too unreasonable, is going to be very important.

I think having some greater uniformity, particularly in areas where you have had the rapid growth like home care, having greater uniformity, going to bundling, will make it easier to the extent that we can figure out comparable examples in Part B.

Out-patient, for example, is something we have not gotten into, but bundling out-patient payments, if we can figure out what the right bundle is, would help, not so much fraud, but with the excessive use problem.

So I think that there are areas that get to excessive use that the bundling can respond to. That is an area that Congress has sent messages to HCFA and the administration to get moving on a prospective payment for out-patient.

I had thought it was about to happen a year or two ago. I would encourage you to press to see where it is, because the parts we tend to talk about, in-patient hospital and physicians, while they are a lot of money because they have had some attention, really have grown relatively slower. Everything else has been explosive growth. Those are areas where, when you put them all together, are non-trivial amounts of money.

Again, in the case of Part B, literally half the money is outside the physician area. It is a little smaller in Part A, but when you have 40 percent growth rates even smaller components can do a lot.

I would be glad to try and think of some more examples. That was off the top of my head.

Dr. ALTMAN. I want to, if you do not mind, go back to your first opening set of comments and just say something that may be obvious to all of you, but let me say it. If you bring down, or save, or reduce the rate of growth in the fee-for-service by $200 billion, you are going to substantially reduce the payments to the managed care companies. I mean, it is an obvious statement but we tend to forget that.

The good thing about that is, we will get some more savings out of managed care. The bad thing about it is, in your area and in Iowa and places like that what is now a barely acceptable AAPCC could turn out to be less bearable. If we do not do anything other than make those cuts in the fee-for-service, you could see this trend line, which has been so positive in the last year or two, turn around.

We tend to forget that one of the reasons why managed care companies are going into other areas is they are finding it very financially attractive. One of the reasons why it has become very financially attractive is because of the growth in the fee-for-service side; a little unfortunate, but something that is obvious.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. This is an educational experience for all of us to hear these excellent witnesses over these past weeks, and I say that again.

Let me get back to Part B, because my friend, Senator Graham, mentioned Part B. This is really going to be an educational exercise

for the American public. Part B premium is really welfare. What do you think of that statement? In other words, Part B is voluntary.

When you bring it up, the senior groups go crazy and talk about the contract made with Americans. But Part B premiums are voluntary; you decide whether to do that. You have a situation which Senator Chafee pointed out to us, and others who have worked so hard in these areas, where, on Part B premiums, a person with a net worth of $10 million or with earned or unearned income of $100,000 a year is paying only 30 percent of their premium on Part B. The guy doing the dishes at the restaurant is paying 70 percent of that person's premium. That is stupefying.

Now, that is where we are with Part B if we cannot get some kind of affluence testing into Part B premiums. In fact, $46.10 is peanuts for a guy, regardless of his net worth or his income.

So I think we are going to have to look into something along the lines of what I and others on the Entitlements Commission proposed, former Representatives McMillan and Goss, where we were phasing in a reduction of Part B premium subsidy for enrollees with incomes above $40,000 for couples and $30,000 for individuals within the incomes index for general price inflation, until finally you got up to paying 80 percent of your premium if you made $100,000 a year. Really not a torture, considering that some poor guy who is making $25,000 is paying $250 or $300 a month for his or her insurance right now.

If we cannot get these things expressed to the American public so they can understand it, we will not get anything done. But Part B premiums must be completely reviewed so that we do take into effect affluence testing.

Do you have any objection to that theory, any of you? Is that crude, evil, unAmerican, or whatever?

Dr. WILENSKY. No, I think it is very important. It is an idea that has been discussed occasionally in the past but not taken very seriously. It is also something we ought to remind ourselves, that the elderly, by and large right now, own their own homes and own their own homes outright, so that when you talk about money income for an elderly person and money income for a non-elderly person you are typically talking about people in very different wealth positions.

I feel very much as you have said, it is unfair, the kind of transfer that is going on between some of the low-income working population and the high-income non-working population. It is actually even worse because Part B is growing at 12.5 percent per year.

We talk about the trust fund, the trust fund is going bankrupt, which it is. But the part that the American public does not think about is Part B, because it depends on the general fund, the general Treasury, as having an even faster growth rate. 12.5 percent is an unbelievably high growth rate, and that is three-quarters funded by general revenue.

So, on equity grounds and on the grounds of trying to make Medicare sustainable and solvable in the long-term, I think the kinds of changes that you are suggesting are important. When you get through with that I think you may even want to look at income re-

lating the other part as well, but you might not want to take that all on at once.

Dr. ALTMAN. Let me just respond.

Senator SIMPSON. Yes, Dr. Altman.

Dr. ALTMAN. Let me just support, in general concept, and add two areas of concern. One, is that we have within the seniors populations very substantial differences in use of health care, given those who are healthy are very healthy often, and those who are sick are very sick, which means that you have very different usages of Part B, both by age and also by health status.

As you increase the amount of premium that you ask seniors to pay themselves, even to 50 percent, you may find the actuary's tale of woe, that the system will begin to unravel, where the healthy leave and the sick stay in, so the premiums that are left have to keep going up higher. So we need to worry about that. We need to do more than just raise the rate.

The second area, to make matters worse, we include within the Part B part substantial funding for our very disabled population, and we not only include it in there but we also include it into these Medigap policies, which means those people, because of their needs, are extracting a lot of money and making everybody else pay.

It is not that they are doing it evilly, but if we move the way you are suggesting I think we need to take a hard look at whether the disabled should be categorized differently and whether health status should be taken into account.

Senator SIMPSON. Well, I agree with that. But, remember, the original formula was 50/50. The beneficiary was supposed to pay 50 percent, the government 50. But, because of politicians messing with it and getting themselves re-elected, they finally got it down to 25 percent from the poor old beneficiary. Now it is 30, 31. This is absurd. We ought to get back at least to the original formula. Does that make your skin creep?

Dr. ALTMAN. With those two caveats, plus some income standard.

Senator SIMPSON. I hear you.

Thank you very much, Mr. Chairman. I mean, we cannot even, in the Veterans' Affairs Committee, get a non-service connected disabled veteran to pay $8 for pharmacy instead of $2. In other words, the co-payment for a non-service connected disabled veteran, they pay $2 a month for pharmaceuticals. We are going to try to raise that to $8. Can you imagine what fun we are having from the professional fund-raising veterans groups on that one? This is non-service connected. It is a great game.

Well, if I felt more strongly about it I would have said something. You want me to go on, do you? Oh, no. No. Thank you, Mr. Chairman.

The CHAIRMAN. I cannot stop you.

We will let Senator Grassley interrupt for a moment.

Senator GRASSLEY. For 5 minutes.

Dr. Altman, I want to ask for some suggestions from you, and they come directly from your statement that "many hospitals are experiencing financial distress. A large number of these hospitals treat large numbers of Medicare beneficiaries. The effect on Medicare beneficiaries served by these hospitals, therefore, must be considered as we examine alternative ways to slow spending growth."

I do not think I have to go into much detail. I have some suggestions on how to do that, but I would like to hear from you.

Dr. ALTMAN. Well, one of the areas that we have avoided because we did not want to make this into a regulatory situation was to worry about the bottom line of an institution and to sort of put our hands over our eyes and make believe that every institution was the same.

And then we got into trouble with rural hospitals and was before this committee, I remember, back 9–10 years ago, where there was a strong negative feeling of this committee that we were not worrying about rural hospitals so we made a number of special adjustments, and we got the same pressure from inner city hospitals, disproportionate share and teaching.

The so called high Medicare hospitals, their whole financial life is determine by what Medicare pays them and does not. They do not have the ability to get extra money from others. We have looked at that hard, and you find substantial differences. Some of them, the reason why they are in trouble is because they have high costs and they need to be concerned about their costs. You do not want to just let them off the hook.

But, on the other hand, if we really bring the average, and not only the average but almost every hospital, into a negative margin, significant negative margin on Medicare, the ones that have 10 percent Medicare will get it from the private patients, but the ones that have 80 percent Medicare, you are essentially forcing them into that situation and it is at that point that you have to say to yourself, do you want those hospitals to survive? You have become their financial lifeline. If the answer is yes, we may not want to treat them quite so negatively as the others.

Dr. WILENSKY. Let me just give one caveat, though, and that is, we have to be careful—especially for some of the high Medicare hospitals this is an issue—not to presume that costs as they have been are necessarily costs as they must be in the future.

One of the things that Medicare has been trying to do in the past—not very successfully—is to force hospitals to change how they do things. In the 1980's, a lot of what hospitals did was just pass it on to private-pay patients in their bills.

Now that has become very difficult because the aggressive private sector is forcing change even much faster than anything Medicare has been considering. But the mainly or heavily Medicare hospitals really have not been pushed in the same way frequently by the aggressive private sector; some of them have, some of them have not.

But we have to be very careful not to assume that someone says, this is my cost structure and, therefore, implies this is as my cost structure must always be as opposed to being able to hire a different mix of health care personnel, a different mix of technology, or finding better ways to do things, or just down-sizing what is a very over-capacity area. I do not mean just hospitals, I mean all of health care.

The kinds of pressures we are seeing in the private sector and the kinds of pressures you are suggesting you are about to impose in Medicare is going to start down-sizing, squeezing out some of the excess capacity in the health care system.

You need to understand that, because it is going to be painful for the institutions and the people that are involved. If you do not understand it, as soon as they start coming and screaming you are going to be apt to want to stop.

But there are ultimately only two ways to try to moderate spending: do it through incentives or do it through direct controls. Now, I do not think this Congress wants to try the direct control strategy, although in the past that is mostly what Medicare has been about. But it will cause change.

Now, you have to look and make sure that you are not troubled by where some of that change occurs, that you do not want to shut out all of the small hospitals, but a lot of what will happen is pressing out the excess capacity that is in the U.S. health care system because the public sector now is going to combine forces with the private sector. That is why the private sector has been successful.

Senator GRASSLEY. Well, one of the suggestions that Senator Dole and I had gotten enacted and now it has run out is the Medicare Dependent Hospital Program. We have 29 hospitals in my State that were making some use of that program. That would be out of 120 hospitals. I suppose that would be 29 out of maybe 90 rural hospitals that you might say we have in our State.

The commission, Dr. Altman, as far as I know, it is my understanding, does not like the Medicare Dependent Hospital Program. I do not want to hear your reasons so much as if you would suggest if there is some variation of that that might be a solution to our problems, at least seeing it as a program that might help hospitals in transition, maybe not forever, you know.

Dr. ALTMAN. Well, in concept, I do not object to it. The problem was in implementation, who qualifies. You open up a door like that and a lot of people want to be in. Unfortunately, we have let too many people in, not so much in that program, but in a lot of these programs.

So with Gail's comments, it is appropriate that we do not want to just reinforce spending what existed in the past, I do believe we need to be very conscious of such institutions, whether it is a transition period or not.

While it may require us not to save quite so much money from them, if we close our eyes to those institutions you are going to do significant hardship to the beneficiaries in those areas. In other areas, though, you do have other institutions and other ways of providing care so I do not think we need to protect anywhere near all of them.

Senator GRASSLEY. I do not even think with a program you are going to protect them. I do not think with a program that precludes any of the goals that Dr. Wilensky said are going to be necessary. I just think what you are doing is helping people over a hump, hospitals over a hump.

Dr. ALTMAN. That is right. Yes. That is why transition makes sense.

Senator GRASSLEY. Yes. From that standpoint then you do not find so much fault with it. I mean, if it does not preclude what Dr. Wilensky said needs to be done and assuming it is not a guarantee of a certain level of expenditure forever?

Dr. ALTMAN. Yes. And if the criteria for getting in there is tightly written so that we are talking about a fairly small number of institutions.

Senator GRASSLEY. Well, if we have 29 hospitals out of 90 rural hospitals in my State, that is out of 120 total hospitals in our State, is that——

Dr. ALTMAN. Well, you start multiplying that times 50, you could wind up——

Senator GRASSLEY. Well, first of all, I do not know that we have that. You find use of these hospitals in a very small minority of the States, I believe.

Dr. ALTMAN. One of the things that I found is that every State turns out to be amazingly rural when it was in the best interests of being rural.

Senator GRASSLEY. I do not think you multiply 29 times 50 States.

Dr. ALTMAN. I know that. I do not want to.

Senator GRASSLEY. I think Kansas is the only other State that has got a significant percentage of hospitals that qualify.

Dr. ALTMAN. Well, as I said, in and of itself, I am not opposed to it. We just need to be concerned about allowing in too many institutions. And I do not know what the right number is because two things happen: the more you put in there the less you save, and two, the more you put in there, what could be a temporary program could wind up being permanent. Unfortunately, we have had a lot of those experiences.

But, in and of itself, I think we are going to be doing some significant changes. Being the kind of person I am, and our commission, we do not want to just see it done all at once. It is just going to do some real harm.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Twenty to twenty-five percent on managed care. CBO might score about that. That is less than all of the optimists want, but I think you are probably right. But I am optimistic.

Let me ask both of you this. We keep Part B at 31 percent and they are $61 billion, you do 25 percent on managed care, there is roughly $70 billion. You are halfway toward the goal with those two things. The other $135 billion is not that undoable, is it, over 7 years?

Dr. WILENSKY. I think that you can do it. I mean, I just do not think——

The CHAIRMAN. I mean, it is doable without overwhelming pain.

Dr. WILENSKY. Going to 31 percent? I did not realize it was quite that high.

The CHAIRMAN. It is. We set it by a dollar amount some years ago and it turns out the dollar amount is not 25 percent, it is 31 percent. But that sunsets the end of this year. If we do not keep it at 31 percent we are going to lose. I mean, if we go back to the 25 percent we lose $61 billion. If we just keep it at the 31 percent, it is $61 billion.

Now, given your $70 billion of managed care and $61 of Part B, we are at $131 billion out of $270 billion. Dr. Altman was about to comment, too. It does not seem to me to be beyond comprehension that we can rationally get the other $139 billion.

Dr. ALTMAN. I would like to see where that 25 percent comes from.

The CHAIRMAN. It comes from Gail.

Dr. ALTMAN. I know. Far be it for me to question my colleague here, but we are talking about 10 percent of the population in managed care maybe jumping to 20 in the short run.

The CHAIRMAN. The short run being what?

Dr. ALTMAN. The next 2 or 3 years.

Dr. WILENSKY. No. I think we were clear that that was——

The CHAIRMAN. You mean the Medicare population.

Dr. ALTMAN. Yes.

Dr. WILENSKY [continuing]. An end loading of the managed care. I think you said, and I certainly agree, that what is going to happen in managed care is probably going to happen in years 4–7.

I mean, what will be required is to make sure that you front load the direct savings that are the typical kinds of savings. I do think that the savings are out there in managed care, but I think they are going to be end year savings and that will require something about how government pays, how Medicare pays, for the choices that the elderly make. But I do think it is doable.

Now, you, of course, have to understand that $135 billion is more than Congress has ever, in fact, legislated in savings in 7 years. We usually think about it in 5 years. But I can recall having come up here talking about $5 billion, $6 billion, $8 billion, and $10 billion over 5 years and not being treated with at least credibility, if nothing else.

The CHAIRMAN. That is because we did not think big enough. You think small thoughts, you get small results.

Senator Simpson mentioned means testing. It is not an overwhelming amount of money because there is not enough rich in this country.

Dr. WILENSKY. Right.

The CHAIRMAN. But the Entitlement Commission, as I recall, suggested means testing at $40,000, or that is what Senator Kerry and Danforth suggested, now Senator Simpson. If you were to start Part B means testing at $50,000 single and $75,000 couple and work it from 25–75 percent, that is $20 billion, just on the means test part of that.

Now, you are going to get screams at $50,000 and $75,000, but, as you both have said, these are people who own their own homes, by and large. And we are not asking them to pay 100 percent. They can opt out of this thing if they want. But $20 billion is not to be sneezed at on just means testing.

Dr. WILENSKY. No. I think, while Stuart raised a question of whether people will opt out, I think that when you are talking about subsidies of 20 and 25 percent or more for all but the very wealthiest, it is hard to beat that incentive.

The CHAIRMAN. Yes. Most people are not going to go without coverage.

Dr. WILENSKY. Certainly not the elderly at that end of the income scale, they are not.

The CHAIRMAN. No.

Dr. Altman, you also talked about therapy services at nursing homes. Give me your idea of what we can save there and how we go about it.

Dr. ALTMAN. Well, our assessment in the skilled nursing area is that much of the growth is because of more and more testing, procedures, and services that are being provided.

The CHAIRMAN. Which we reimburse on a cost basis, in many cases.

Dr. ALTMAN. Which we reimburse on a cost basis. There are several possibilities. One, is to pay for those services on a fee basis similar to the way we pay for the same services through the RBRVS. My understanding is, actually, CBO is trying to figure out what kind of savings that would generate.

Two, is to begin to even talk about moving those services into some prospective system and to go to some form of limited budgets similar to the way we are talking about for home care so we can begin to offer these nursing homes a mini-capitated rate, if you will, or, in fact, a limit that does not allow them to just continue to provide more services, whether it is a fee or a cost basis.

Some of these things are more thought out than others. What has happened, Senator, is that these were small programs, home care, skilled nursing, and we worried about the big programs and we focused all of our attention on them. All of a sudden, we woke up 1 day and they are not so small anymore. So the kind of really thoughtful processes that went into the hospital and the physician side need to be directed to these other two programs. Unfortunately, we do not have a lot of time.

Now, I am where you are. I think we should be prepared to jump, even though we do not have every "i" dotted and "t" crossed, and try to learn while we are doing it. We will make some mistakes, but the alternative is to either hit the beneficiaries with everything or go after the traditional areas, hospitals and physicians, where we have already been banging them around, which does not make a lot of sense to me. So I think we should be aggressive.

The CHAIRMAN. You know, I totally agree with what you say. At some stage we have got to make a leap of faith. I do not mean unjustified optimism and bogus figures. But, if we are to sit here until we are satisfied we have written the perfect bill and we know perfectly the answers, we will not write any bill. There is no way we can know.

We can make a best estimate. You can give us your best judgment and then it requires a bit of faith. But you say, if we do not do something, some control of some kind, we know what the end is going to be and the end is not acceptable.

Dr. ALTMAN. I would just add to that, which I support, that we develop good monitoring systems so we know what we have done after we have done it. We had a hearing last week before the Commerce Committee in the House and we were talking about some experimentation and picking a few areas and doing it over 3 years.

I, quite frankly, threw my hands up, for two reasons. First of all, we are not playing with a test tube where you keep the rest of the system the same and you are playing with a part, we are dealing with a fundamental change in the whole system.

I think we ought to think about the total system is up for experimentation and, therefore, be bold, but also monitor, evaluate it ongoing, make sure that if things look bad we change them quickly. Unfortunately, often we have let good things go too long and we have let bad things go too long.

So, if we are going to be aggressive we also should develop some monitoring system that allows us to come before you quickly, as well as the administration, to tell you when things are not working right.

The CHAIRMAN. But even that should not be hard to put in place, should it?

Dr. WILENSKY. A lot of it exists. In terms of access for the Medicare program, that actually is not so hard. It will be a little more serious for the Medicaid program. You have been quite careful because of the aggressive moves that you have made in the hospital and physician parts. You have required a lot of monitoring for the Medicare program.

Whether or not some survey work, which is a lot less expensive than an administrative structure that is a universal measure of individuals, may need to be put in place if you make the kind of changes that are being suggested with Medicaid, that is different. But actually I think you are in quite good shape for Medicare.

Dr. ALTMAN. We need to be a little careful—I am way beyond my capacity—about the law and what the courts will allow you to do. One of the lessons we learned is that there was a fairly aggressive set of steps taken on home care and skilled nursing care by the administrations back in the 1980's.

Then the courts really came on very strong and essentially wiped out, not only the extra safeguards that had been put in place, but the safeguards that had been there before. Much of the growth in home care and in skilled nursing care is a direct result of the administration being forced by the courts to sort of just do away with a lot of things.

The CHAIRMAN. I will give you an example. It is one of the complaints. It is the so called Boren Amendment where the lawsuits are brought by the nursing homes, and the courts say, the law says you have got to do X. Well, whether we intended X or not, I cannot remember. But that is an example of what you mean by the courts, such as the Individual Functional Assessments under SSI, where I am sure we never intended the breadth of coverage in that program. Had we thought about it, we would have said, no. But the courts interpreted it that way.

Dr. WILENSKY. It does indicate the point that I think Senator Graham, and that you also raised, that occasionally ambiguity is desired or at least the unintended consequence. It sometimes has very profound results.

The Boren Amendment is probably a very good case in point. It has been an extreme problem for States. They are constantly in the courts. There does not appear to be a rational economic comparison that is made. It usually is, the average charge in a State has been interpreted as what an efficiently organized hospital would otherwise charge in a system that is running at 60 percent capacity. But it has had very profound effects.

What you will have to be very careful about is, as you are writing new legislation, the potential for having equally profound effects is obviously there, and try to catch as much of that as you can going in.

The fact is, as you sit in session each year and probably, in part, the optimism we can feel is that, if there are errors and there are monitoring systems you have a frequent opportunity to correct them if there is the will to do so.

Dr. ALTMAN. We do need to do better on our quality monitoring, though. We really do not know as much as we should about what is really quality medical care. We have often, in spite of all the talk, defined more as better and less as worse.

The CHAIRMAN. Well, it was encouraging to see the last reports coming out of the Jackson Hole group of the major HMO and larger industrial carriers. They are going to start to look now toward quality. They are getting a handle on costs.

Dr. ALTMAN. And the large corporations are, too. I mean, the negative comments that corporations are only interested in saving money has not been my experience. They want to make sure they are getting good value for their money, but they are not prepared to let themselves and their workers just get substandard care.

So, yes, I think the managed care companies are doing it and I think they are being pushed very hard, and should be, by the corporations. I think we ought to be pushing them harder. I do not really know.

The CHAIRMAN. We used to see this on Worker's Compensation years ago when I was in the legislature. The way that companies that wrote industrial accident insurance could make money was to get your safety rate better and better because their premiums were based on your past history on safety.

So, to the extent that they could make you more safe, which was better for the employer and better for the worker, they made money. You see this in health care. It is not worthwhile to General Motors to have a sick labor force.

Dr. ALTMAN. Right.

The CHAIRMAN. I do not think I have anything more. Thank you very much. We will see you again next week, Gail, for something.

Dr. WILENSKY. Thank you.

The CHAIRMAN. Thank you.

Dr. WILENSKY. Any way I can help, Senator.

[Whereupon, at 11:24 a.m., the hearing was recessed, to reconvene at 9:30 a.m. on Thursday, July 20, 1995.]

MEDICARE PAYMENT POLICIES

THURSDAY, JULY 20, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to recess, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Moynihan, Baucus, and Graham.

OPENING STATEMENT OF HON, BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order, please.

Gentlemen, we are glad to have you with us today. This is the second of the series of hearings on providers.

We have had numerous Medicare/Medicaid hearings all winter, spring and summer, attempting to prepare this Committee for how we meet the budget reconciliation's goal that we slow the increase in the growth of Medicare from about 10 percent to 7 percent a year.

It is still a significant increase, but it is a reduction of about $270 billion over 7 years from what we would otherwise spend. It is still up significantly, but down from what we would otherwise spend if the law was not changed. And this Committee is under order to produce that $270 billion. If we do not, the Budget Committee is free to do it in any way that they choose. So I am hoping that we can find a way to do it in a way that is not harmful to the basic Medicare system.

Second, as you are aware, Medicare is verging on bankrupt. Ever since 1992, we have been paying out more money in Medicare benefits than we take in in taxes. And the only way that Medicare has kept its head above water is that it had some interest income on surplus bonds that it held, and some other modest income. So its operational costs roughly equal its operational income.

But, as of 1996, that does not even work, and they have to start redeeming the bonds that they hold in their trust fund. And, by the year 2002, all the bonds are gone. At that stage, it is nothing but pay in, pay out unless we change it. And the pay in from worker taxes is way, way short of the projected benefits. So we have got to do something, literally to save the system, let alone trying to hit our total target of $270 billion, in addition.

With that, I will call on Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, just to echo your views exactly, with one further comment.

When we put this arrangement in place 30 years ago, we had a model of a Government program which really does not work. All the incentives are to expand outlays, and not otherwise.

I do recall, since I was in Government at the time, in the Labor Department, that the expectations on what this would cost were very modest. Medicaid turned out to be an enormous sum, as we have now learned.

And yet they put in place a system which is open-ended as to what demands will be met. Next thing we know, as Max Greenfield said of Medicaid, "It is the program that ate New York."

We may have to ask ourselves about this whole structure. But, in the meantime, the fact of a fiscal crisis, which is now upon us, is clear. I do not know what is on it, but I would not want to see the budget.

Thank you.

The CHAIRMAN. Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you very much, Mr. Chairman.

Mr. Chairman, I appreciate your calling this hearing. I understand that we are going to hear a lot of identical, but important, testimony about how we might make our program more efficient.

Where we can make savings that do not harm the level of service to our seniors, I think we should do so. It is important to make savings wherever it is appropriate. That is because Medicare clearly faces serious problems.

And I very much hope that we, together, in a bipartisan way, can work to find those savings and ensure long-term stability.

As we sort through the details, I think it is important that we keep our eyes on the ball. We must not forget what Medicare really means to an awful lot of people. Sometimes we in Washington, DC seem to forget.

Not long ago, for instance, I was going through my mail, and a letter from Irene Terwolbeck caught my eye. She tells me that she is German, and that she is the only Terwolbeck in the whole State of Montana. She wrote telling me that she and her husband, Larry, live in Joplin, MT. That is a small farming community, up on the high line. Some of you who may not know Montana very well may be interested to know that, along the northern tier of our State, we have a highway that crosses the State, and we call it the "HI-Line line." Joplin is a small town on the HI-Line.

After learning that the budget resolution had just passed Congress, and that it would make deep cuts in Medicare, here is what Irene had to say in her letter to me, and I quote, "I did not sleep well that night. And I wonder how many other seniors did not either. My husband and I could not afford to pay much more. We have no income except $700 a month Social Security, and $6,000

a year from land we placed in the Conservation Reserve Program. To give the wealthy a tax break, at the expense of the needy, is grossly unfair."

I agree with Irene; she makes a lot of sense. And her situation is hardly unique. In Montana, for example, more than one-eighth of our total population is age 65 or older. And 70 of those senior citizens have an annual income below $15,000. Again, one-eighth of our population is 65 and older. Seventy percent of that population has an annual income below $15,000.

So, when you think about it, that is not a lot of money to keep your head of above water, especially in the face of increased medical bills, and the prescription drug costs that so many of our seniors must deal with.

Earlier this week, a document was released by the House Ways and Means Committee that I found very troubling. We all know that $270 billion, the amount the budget resolution says must be cut from Medicare, is a lot of money. But what does it mean to people like Irene Terwolbeck? The document begins to provide some answers.

First, it may mean that she has the option of obtaining a voucher that she could use to join a Government-approved health maintenance organization. If you have ever been to Joplin, you will know that it will never be anywhere near an HMO. Most areas in large, sparsely-populated States like Montana simply do not have a population base to support an HMO.

The theory is that HMO's will bring costs down. But, in places like rural Montana, I do not think this theory will ever become a reality.

So, for Irene, and most other Montanans, the only option is to stick with traditional fee-for-service Medicare coverage. And, according to this House plan, that means that Medicare costs for these seniors will skyrocket.

Copayments, the share Medicare recipients must pay out of their pockets, would go from 20 to 25 percent. So, for example, Medicare recipients would be forced to directly pay $25 for a $100 doctor bill.

Deductibles would rise. By the year 2002, this plan would require those on Medicare to pay $270 each year before Medicare kicks in. That is $170 more than the present $100 deductible.

And, last but not least, this plan calls for more than doubling the present $46.10 monthly Medicare premium.

And what would the millions of Americans, who would be asked to pay more under this plan, receive in return? Would they get better health care, prescription drug benefits, a Medicare system on more sound footing? Or will they simply be asked to foot the bill for tax breaks for the very wealthy? The devil may be in the details.

I look forward to working with my colleagues, Democrats and Republicans, to protect the Medicare program, but to do so in a very fair way.

Thank you, Mr. Chairman.

The CHAIRMAN. If I might just add a geographic twist to that, Max, as I mentioned yesterday.

In the Portland metropolitan area, we have now exceeded 50 percent Medicare HMO enrollment on a voluntary basis. There are

seven companies competing with other in selling plans. All of them have to provide the basic Medicare coverage. You are not allowed to sell any plan other than that. And they get 95 percent of the normal Medicare fee.

But, beyond that, they have a variety of different benefits. And people sign up according to what they think they need. One of the plans does not offer prescription drugs. And I assume that the people who sign up for that do not need many prescription drugs. They think, why should I pay for a plan that gives them, when I do not need them?

The interesting thing is in the rural areas. Oregon adopted a Medicaid plan some time ago. It has been in effect for a year and a half now. Basically, everyone in Oregon on Medicaid is going to be into managed care.

And this means, in the rural areas, the managed care infrastructure is now being set up. In fact, it is set up for Medicaid. Doctors have formed groups, and they are bidding on Medicaid. The seven carriers are now moving into the rural areas. They started this year on HMO coverage for Medicare in rural areas. And the sign-up is tremendous. There is a network among the seniors, and they do talk to each other. We are having great success, on a voluntary basis, with people signing up for managed care Medicare.

Senator BAUCUS. Yes, that may be, Mr. Chairman. But we do not have a Portland, which is a base for all of that.

Second, just generally, rural health care over the years has always been sort of a second cousin. It just has not been as good as urban health care.

As you well know, over the years, even when we were on cost-based reimbursement, and moved to prospective reimbursement, there is always a problem with rural health care.

Even though HMO's may make some attempt in some places to provide health care in rural areas, I suspect that rural health care is still not going to be quite as good as urban health care.

It is just clear that this House plan to cut Medicare is one that is going to have a very deleterious effect on seniors who live in rural areas over the next several years.

The CHAIRMAN. We will take you gentlemen in the order you appear on the witness list.

We will start with Kenneth Aitchison, who is the president and chief executive officer of the Kessler Institute for Rehabilition, one of the best—if not the best—known rehabilitation institutes in the country.

Mr. Aitchison?

STATEMENT OF KENNETH W. AITCHISON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, KESSLER INSTITUTE FOR REHABILITATION, WEST ORANGE, NJ

Mr. AITCHISON. Thank you, Mr. Chairman.

As you mentioned, my name is Ken Aitchison. I am president of Kessler. I am appearing here today on behalf of the American Rehabilitation Association.

I have worked in medical rehabilitation for approximately 30 years, the first 13 at the University of North Dakota Rehabilitation Hospital and, since 1979, at Kessler.

Kessler is a four-location, 320-bed rehabilitation facility in Northern New Jersey. You perhaps best know us through the recent admission of Mr. Christopher Reeve, who is currently a patient at our Kessler West facility.

Medical rehabilitation addresses a single end—the elimination or mitigation of disability. Most of our patients come to us from acute care hospitals, about 400,000 per year. They are admitted to approximately 200 free-standing rehabilitation hospitals such as ours, and about 800 rehabilitation units. In addition, many more are served as outpatients.

Many of the conditions that require admission to our facilities are conditions associated with advancing age. As such, we see a lot of Medicare beneficiaries. Therefore, the policy changes that you are considering for Medicare will perhaps affect our field of health care more than any other aspect.

Rehabilitation facilities are reimbursed under what is known as a TEFRA system, a system adopted in 1983 as a temporary measure—reasonable cost per-discharge ceilings.

There are three particular problems with that system: One, it does not adjust for change in case mix or increased acuity; two, it places pressure upon us to cut average length of stay, as a means of reducing per-discharge cost and; third, it overtly encourages and subsidizes new providers.

With respect to this, we recommend that you consider TEFRA limits for new providers at 150 percent of the national average and, for established providers, a floor of 70 percent.

A long-term and more permanent solution would be a replacement of that system with a prospective payment system. We have worked on such a system, known as functional related groups, FRG's. HCFA has looked at it, and they are considering awarding a contract in that regard. We think it would be a good building block, and ought to be expedited.

In the long term, compensation to all providers ought to be based on services provided, and certainly should eliminate the perverse aspects of reimbursing, and avoiding the reimbursement, or the service for severely disabled patients.

A PPS for rehabilitation, even if budget neutral upon adoption, would result in considerable savings to the Medicare program, if the subsidies for new providers were eliminated.

We also recommend that the Medicare Act be amended regarding the definition of a rehabilitation hospital or unit. To qualify under Medicare, our facilities must currently admit 75 of its discharges in 10 diagnostic categories.

This is a system based upon practice patterns of 20 years ago. We believe that four additional diagnostic categories—pulmonary, chronic pain, cancer and cardiac—should be added.

We also recommend that basing TEFRA limits for long-term care hospitals be placed for current costs. The FRG system, about which I spoke, does not necessarily apply here. And certainly TEFRA causes the same frustration for this segment of our delivery system.

Bundling with the acute care hospital reimbursement has been proposed as an effective way of reducing costs. The rehabilitation field, in general, is opposed to such a bundling prospect because of

its potentially adverse effects of patient care. Namely, it creates a conflict. There is a strong financial incentive to deny or to abridge rehabilitation services.

Further, there is no basis for computing the amounts by which DRG's ought to be increased to cover rehabilitation. And, there is no current system to monitor whether care is appropriately provided under such a system.

The likely result, therefore, will be higher acute medical costs, as patients do not regain function and independence.

Managed care, about which you spoke earlier, has been suggested as one of the effective ways to decrease the increase in overall Medicare expenditures. In general, there is a low rate of enrollment in such programs—9 percent.

In concept, there are two good reasons that such a program works. One is to achieve economies of scale. From the provider perspective, that is a way of driving hard bargains. And the second is to avoid the delivery of ineffective or superfluous services.

In fact, there is a third factor, and that is the denial of services. It is unlikely that a person shopping for HMO coverage will anticipate the need for, and coverage of, rehabilitation services. Managed care should not be used as a way to deny rehabilitation care or other specialty services.

We recommend that managed care plans enrolling Medicare beneficiaries fully describe coverage of rehabilitation services. And any limitations on such coverage should be clearly delineated.

We have presented in our written testimony five suggestions as to how that might be accomplished—assessment, quality, proper gatekeepers, due process and an opt-out provision.

Mr. Chairman, Members of the Committee, I thank you for the opportunity to speak before you. The actions you will take will have a profound impact upon the Medicare population, and particularly those with disabling conditions. We hope our ideas will be of benefit in your considerations.

The CHAIRMAN. I thank you very much.

[The prepared statement of Mr. Aitchison appears in the appendix.]

The CHAIRMAN. Next we will take Phillip Hoffman, who is the chief financial officer of Outreach Health Services, but he is speaking today on behalf of the Home Health Services and Staffing Association.

STATEMENT OF PHILLIP I. HOFFMAN, CHIEF FINANCIAL OFFICER, OUTREACH HEALTH SERVICES, AUSTIN, TX

Mr. HOFFMAN. Mr. Chairman, my name is Phillip Hoffman. I am the chief financial officer of Outreach Health Services, which provides Medicare-covered home health services throughout the State of Texas through both for-profit and non-profit organizations.

I am testifying on behalf of my company and the Home Health Services and Staffing Association, whose diverse membership includes both large and small home care providers, which operate over 1,500 offices in virtually every State, and employ nearly half a million caregivers.

My work experience includes participation in both Phase I and Phase II of the prospective payment demonstration projects funded by the Health Care Financing Administration.

I have also participated in the PPS work group, which consists of representatives from for-profit, non-profit, hospital-based and free-standing home health agencies. It has been working over the past year to develop a prospective payment system. The work group has developed the prospective payment proposal I will describe today, as an alternative to copayments.

To place this discussion in context, home health expenditures currently constitute approximately 11.5 percent of Part A spending, and just 7 percent of all Medicare spending.

Increasing concern has been expressed by ProPAC and others, however, over the rate of increase in Medicare expenditures for home health services, which has approached 25 percent over the past 2 years.

While much of that growth can be attributed to the trend of providing health care outside of the institutional setting, there is concern that some of that growth may be caused by the current cost reimbursement system, which provides an incentive to furnish unnecessary visits, incur unnecessary costs, and unnecessarily extend services to patients.

The current system provides no incentive for home health agencies to operate efficiently. Overlaying copayments on the existing system does nothing to curb the inefficiency and abuse caused by that system. Copayments simply shift a portion of the cost of that inefficient system to the patient, in the form of a "sick tax", and erect a barrier for those who need care, especially the elderly with low incomes.

Imposing copayments also creates an incentive for patients to remain in the higher-cost hospital setting, because there is no copayment on the first 60 days of hospital care covered by Medicare.

Copayments also further burden the Medicaid program because certain beneficiaries are eligible to have their copayments and deductibles covered by Medicaid.

There is general agreement in the home health industry that high quality services can be provided in a more cost-effective manner through prospective payment.

The PPS work group has developed a plan, and had it scored by the accounting firm of Price Waterhouse. Their conservative estimate of savings which can be generated by this plan is between $19 billion and $29 billion over 7 years.

Mr. Chairman, at the request of your staff, the proposal is currently being reviewed and scored by CBO, and we thank you for your help with that.

A detailed description of the plan is attached, but the most significant features are as follows:

One, a cap would be established on the aggregate payments that any home health agency could receive from Medicare, in any fiscal year, based upon the episodes of care rendered by the agency.

Two, providers would be allowed to share in up to 40 percent of the savings achieved by keeping their payments for the year below the aggregate per-episode cap. Providers, therefore, would have an

incentive to control utilization, a concept absent from the current system.

Three, to maintain cash flow, home health agencies would be reimbursed for visits at a prospectively set rate, based on the average regional cost of service.

Four, the per-visit rates on the per-episode caps would be established for a base period and updated annually at a rate that is less than the projected growth rate in expenditures.

We believe this proposal has the following advantages: It provides and effective mechanism for the Government to control the growth rate in Medicare home health expenditures, while preserving freedom for clinical decisions to be made by the physician, the patient and the provider.

It creates incentives for home health providers to become more cost-effective and innovative, and rewards those who do.

It achieves true savings to the overall health system, rather than shifting costs to the patient or other programs.

It avoids needless administrative costs, thereby helping to preserve home health services as a low-cost treatment option.

And it significantly reduces the incentives for waste and abuse.

We do not contend that the work group proposal is the perfect prospective payment system, or the one that might ultimately evolve. In fact, the plan is designed to be refined as experience is gained and data is generated over the next 3 years by the Phase II demonstration project.

We are also coordinating with the National Association for Home Care in the development of this proposal, and believe that there is agreement with respect to the plan's basic concepts. We believe, however, that the proposal is far superior to the current system with copayments.

This Committee expressed its intent in OBRA 1987 and OBRA 1990 that home health reimbursement be switched to prospective payment. That intent has not been fulfilled, reportedly because no prospective payment system was ready for implementation.

After 9 years, it is clear that we will never have a prospective payment system ready for implementation without explicit direction from Congress.

In an exchange yesterday between the Chairman and Dr. Altman, Dr. Altman observed that we cannot afford to wait for the development of a perfect plan, or perfect legislation. The work group has developed a system, with broad industry support. It saves money, improves efficiency, and avoids penalizing the patients or cutting the benefit.

Rather than adhering to an antiquated, inefficient system, or making it worse with copayments, we believe it is time we got on with implementing a prospective payment plan.

I appreciate the opportunity to present this proposal, and I will be glad to answer any questions.

The CHAIRMAN. Thank you very much.

We have been following with interest what you have been doing. And you are right. We have had since 1982 to get ready for a prospective payment plan at some stage. And this is definitely bipartisan criticism. This has gone through Democratic and Republican

administrations. And, as you say, we have had enough time. If they are not going to act, we have to act.

Mr. HOFFMAN. Right. We agree.

Senator MOYNIHAN. Mr. Chairman, would you not agree that if something does not happen, keeps not happening, there is some systemic reason? I do not know what it is, but there is something out there that is trying to stop it.

The CHAIRMAN. You may be right. It is not a conscious slipping. It is that we have decided that nothing should happen.

Senator MOYNIHAN. It is systemic, and needs rehabilitation.

The CHAIRMAN. Next we will take Dr. David Sundwall, who is the president of the American Clinical Laboratory Association.

Doctor, good to have you with us.

[The prepared statement of Mr. Hoffman appears in the appendix.]

STATEMENT OF DAVID N. SUNDWALL, M.D., PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION, WASHINGTON, DC

Dr. SUNDWALL. Thank you, Mr. Chairman.

I am pleased to be here today to testify on behalf of the American Clinical Laboratory Association. However, I am also a family physician. And I can tell you from first-hand experience the inestimable value of clinical laboratory services in the prevention, treatment and diagnosis of disease.

Given the time limits this morning, I want to make just three points.

One, Medicare expenditures for clinical lab services have disproportionately declined in recent years, compared with other providers.

Two, the imposition of coinsurance or copayments, as we have heard from some other witnesses this morning, we will not reduce utilization of clinical laboratory services, as proponents intend, nor will it likely result in the anticipated savings.

Three, currently there are some regulatory obstacles which impede our ability to provide appropriate utilization and efficiency of clinical lab services, which we would appreciate your attention to.

Let me explain—first of all, declining payment or expenditures for clinical lab testing. If you would indulge me, I would like to show some charts. The first illustrates that over the past 10 years, laboratory payments have frequently been targeted for cuts in order to reduce Medicare Part B expenditures.

Lab services constitute approximately 6 percent of Medicare Part B. However, as this chart illustrates, budget reconciliation laws enacted since 1984 have repeatedly sought and achieved cuts in this category.

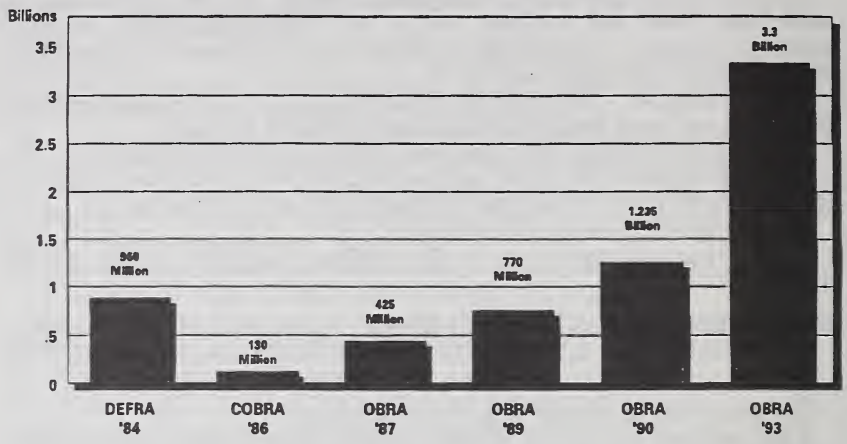
Please note that this bar graph illustrates the magnitude of reductions in payment, not growth.

The CHAIRMAN. Say that again. I do not have the chart here in your testimony, so we are trying to read that chart over there.

Dr. SUNDWALL. I apologize for that. I should have had that to you in advance. But the bar graph illustrates the magnitude of reductions in payment, not growth.

[The graph referred to follows:]

History of Cuts in Laboratory Payments



Figures Reflect Savings from Laboratories

Source: "The Green Book" 1986, 1987, 1989, 1991, OBRA '93 Conference Agreement, and HCFA Documents

The CHAIRMAN. All right. The bigger the bar, the greater the reduction in payments?

Dr. SUNDWALL. Right.

The CHAIRMAN. All right.

Dr. SUNDWALL. So, when you enacted OBRA 1993, you really did it to the labs. That is $3.3 billion over the ensuing 5 years.

Also, when you enacted those cuts for laboratory services, I want you to understand that that translates into real reductions in payment from 1 year to the next, not just a less than expected growth, as is the case with other providers. In other words, less money from 1 year to the next.

These Congressional actions, coupled with dramatic changes in the private sector, have resulted in a decrease of more than 10 percent in Medicare Part B expenditures between 1993 and 1994—that is payment for those services done by independent labs and in physicians' offices.

The second point I would like to make this morning is that ACLA appreciates the imperative you are under to reduce Medicare expenditures. We are absolutely committed to working with you and your staff to identify how additional savings might best be achieved from clinical laboratory services.

However, I want to take just a minute to tell you why we feel so strongly that the 20-percent copayment for clinical labs is a bad idea. It will not result in reduced utilization, as I have said.

Both the Office of Technology Assessment, and the Congressional Budget Office have studied this specific proposal for labs. And both of them concluded that it is not likely to reduce utilization. As the

CBO said in their report in February, "Generally, these decisions are left to physicians, and they do not appear on enrollees' cost-sharing." (CBO—Feb. '94).

Furthermore, while coinsurance is intended to promote cost-sharing, the burden will fall primarily on the labs.

The example I have chosen to illustrate with the second chart is pap smears. Medicare pays $7.33 for reading a pap smear. It costs us approximately $3.00 to bill. The copayment for a pap smear, 20 percent, would be $1.47. If we bill twice, which is often the case, our costs would considerably exceed what we would ever hope to recover.

[The chart referred to follows:]

COLLECTION COSTS OFTEN EXCEED COINSURANCE

Maximum Medicare Payment for Pap Smear	20 Percent Coinsurance	Cost/Bill	Average No. Bills	Total Cost
$7.33	$1.47	$3.00	2	$6.00

Dr. SUNDWALL. The last point I want to make is that we really would like to improve the efficiency and appropriate utilization of lab services. While Congress appears to be working diligently to simplify Government, and make it more user-friendly, let me point out one example of what I think is an explicable HCFA policy related to payments for lab services.

HCFA is required by law to pay only for what is medically necessary. They should be prudent purchasers of health care, and, as a taxpayer, I support this. But, in an attempt to accomplish this, they have come up with an incredibly burdensome and complicated mechanism for lab payments.

Without boring you with the details, I will just tell you that they are now encouraging Medicare carriers to require physicians to put a diagnostic code, called an ICD–9 code, on many laboratory tests.

I cannot think of a better example of a hassle factor, which drive doctors nuts, if not out of practice. And the labs are often left holding the bag, because they are denied payment for services which we provided in good faith upon a physician's request, if the ordering physician does not provide the coding information.

Now I will not read this; it is simply a visual aid. But this is our compilation of the rules published by Medicare carriers in 20 States, all of which are different, complicated, cumbersome and costly for us to comply with.

We strongly encourage Congress to pass legislation which will help us serve Medicare beneficiaries more efficiently and economically, by reducing some of the regulatory hassles.

The provisions which we think would be helpful include: One, enabling labs to deal with a single carrier; two, promote uniform national policies for medical review; and, three, require direct billing for all lab services, for all insurers.

The importance and potential benefits of these provisions are discussed in my written testimony.

Thank you very much. I would be happy to answer questions.

The CHAIRMAN. Doctor, thank you very much.

[The prepared statement of Dr. Sundwall appears in the appendix.]

The CHAIRMAN. We will conclude our testimony this morning with Dr. Paul Willging, who is the executive vice president of the American Health Care Association.

Doctor?

STATEMENT OF PAUL R. WILLGING, Ph.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Dr. WILLGING. Thank you, Mr. Chairman.

You have posed a true challenge for us, today and over the next few months, to assure the solvency of Medicare program while at the same time adhering to our social commitment to the elderly, who are so dependent upon the Medicare program. We look forward to working with you to achieve those goals.

When one is looking toward saving money, in either of these entitlement programs, Medicare or Medicaid, there are really only three places we can look. There are not four, not five, there are only three—the number of beneficiaries, the services provided to those beneficiaries, and the prices we pay for those services.

In today's hearing, we are not going to be talking about the numbers of beneficiaries, but we will be focusing on the other two factors, namely the services provided and the prices paid for those services.

To some extent, I would agree with my colleague, Dr. Sundwall, that there comes a point when, in terms of prices, you probably have squeezed about as much blood out of that turnip as you can.

And I appreciate the recognition by you and many of your colleagues that, if you go beyond the point of there being no blood left, that squeezing has two deleterious effects. You are either going to reduce the quality of the services provided, or you will occasion cost-shifting to other payers within the system.

But we still want to work with you. If there is any blood left in that turnip, we will try to find it with you. And, in the area of prices, I think there are four or five things we can look to.

First of all, we have—reluctantly admittedly—accepted an extension of the President's proposal with respect to routine cost limits, even though by the year 1997, 2 years hence, 8 out of 10 nursing facility providers in this country will have exceeded those cost limits, and essentially will not be receiving reimbursement of those costs. But, with such an extension, there is $1.3 billion available over the 7-year period.

We are also working with HCFA to develop a prospective payment system for the skilled nursing facility benefit in the Medicare program, which would bring us about $1 billion worth of savings.

I would hasten to add, however, that this is because HCFA has proposed that full implementation of that system cannot take place until 1998. That is not our preference. We have, in fact, been working closely with HCFA toward a much earlier implementation of a PPS system for the SNF benefit, but the delays appear to be constant.

We would also restructure the copayment for the SNF benefit. The copayment in the SNF benefit has a very perverse implication.

Essentially, it wipes out the benefit after 20 days, since the copayment under SNF's is tied to the hospital payment. After 20 days, when the copayment kicks in, the copayment is at about the same level as the cost of the day of care in a skilled nursing facility.

We would substitute for that a 20-percent copayment across the entire length of stay, which would bring about $2.6 billion over the 7-year period.

Now let me get to the area of ancillaries. Dr. Altman chatted a tad yesterday about the role of ancillary use in skilled nursing facilities. And I would propose a three-pronged approach to deal with that issue, whether it is fraud and abuse, or whether it is overutilization, and whatever the level of ancillary use.

I would suggest that, one, we pay more attention to the role of the nursing facility in coordinating and overseeing the bills otherwise submitted by vendors directly to the Government.

Two, we utilize the plan of care required for every patient in every nursing facility as a utilization control mechanism rather than as a method simply to add more and more services into the equation.

And, third, we begin to look to paying for ancillaries on a fee-schedule basis, rather than the current system, which is largely cost-related.

At some point though, Mr. Chairman, we have to move from looking at prices to looking at coverage and the services provided. Every managed care entity has recognized that, at some point, they have to move from what they have traditionally done early on, which is simply price negotiation, into what is truly managed care.

When we look at managed care, we have to look to services. We have to look to how much; we have to look to where. And I think, in terms of copayment, utilizing the plan of care more effectively, getting physicians more involved in attesting to the need for those services within the facility, we can perhaps deal with the how much. However, we have to deal ultimately with the issue of location. Where the service is provided plays a key role, in terms of the cost of that service.

Now we have perhaps used the term "subacute" too much in this town over the last few months. It serves more as a lightning rod than anything else. I would prefer to simply talk about substitution. I do not know how much of the increased cost of the SNF benefit has been due to substitution—that is, substituting for more expensive hospital care.

But, as some of our managed care colleagues have shown, there is in fact a direct inverse correlation between the utilization of hospitals, the upper line, and the utilization of the skilled nursing facility. They tie together.

Indeed, in ProPAC's June report, ProPAC's preliminary data shows that, in communities which have a high cost for SNF benefits, there appears to be a corresponding lower cost in terms of hospital utilization.

The last chart will, in effect, show you exactly why that is possible. There are five DRG's that clinical panels put together by Abt Associates looked at, which showed that there was, in fact, no rea-

son that these five DRG's could not be adequately handled in a subacute skilled nursing setting.

For one of them, DRG 410, chemotherapy episode, one can take a $4,500 cost of care, and drop it down to $1,400.

And I will conclude by suggesting, there are some who have said that, as we move into this, it might take some time. If we were to start just with the five DRG's that the panel suggested did not need intense hospital care, and could be handled in a skilled nursing facility, that alone brings us close to the $4 billion in savings within a 7-year period.

Thank you very much.

[The prepared statement of Dr. Willging appears in the appendix.]

The CHAIRMAN. Thank you, doctor.

Dr. Sundwall, you are both a practicing physician and a clinical lab?

Dr. SUNDWALL. Right.

The CHAIRMAN. Why is it that the physicians are opposed to the laboratory direct billing?

Dr. SUNDWALL. Well, actually, I spoke with the head of the AMA in Chicago about this very issue last November. He told me that their official policy is not opposed to this provision because their ethics committee tells them that it is the right thing to do.

The CHAIRMAN. Is their official position not opposed, or will they now support it?

Dr. SUNDWALL. I am not sure they will come out supporting it. But he personally told me that they had reviewed this. The reason, of course, that we want it is that it is an administrative simplification.

There is a tendency—and it has certainly been well documented—on the part of physicians to mark up lab services 100 percent, 150 percent, or even more. And that is an expense to the system, sometimes passed on to the beneficiary, that should not be there.

We think that there are economies of scale for the Medicare program. Although Medicare already pays directly to labs for their services, we have done a study which shows that in States where they also require other insurers to pay directly, even Medicare payment for lab services declined.

Apparently there is a spillover effect in the ordering pattern of physicians. Where they understand there is no financial incentive from ordering more lab tests, they are more appropriate in their ordering practices.

The CHAIRMAN. You mean fewer lab tests?

Dr. SUNDWALL. Exactly.

The CHAIRMAN. That is interesting.

Mr. Aitchison, let me ask you, your group supports limiting the costs of the new rehabilitation hospitals, and a prospective payment system, where feasible. I was intrigued with your formula.

You realize we have to live and die by the Congressional Budget Office savings. Senator Moynihan once said that there is no guarantee that they are accurate, although they are pretty good. But at least it is uniform set that we live by. Otherwise, we would have everybody's set of statistics.

Would you support reducing the annual inflation rate for your hospitals, if the savings cannot be produced in the way you suggest?

Mr. AITCHISON. Depending on the degree, I think yes, Mr. Chairman, I think that could be done. Under OBRA 1993, as I understand it, its extension could provide for a reduction of the increase by taking market basket minus whatever percentage you come up with. We could do that.

The CHAIRMAN. All right. That is encouraging. This is an encourage panel today. Actually, they are very helpful.

Mr. Hoffman, let us give you $25 billion—no, no. [Laughter.]

You have indicated that the current Medicare payment system just has no cost saving incentives for providers. Would you elaborate a little more?

Mr. HOFFMAN. The way the present Medicare reimbursement system works in home health is a cost reimbursement system. There is no incentive for providers to be efficient. There is no incentive for them to reduce their costs. As they reduce their costs, and become more efficient, their reimbursement simply is reduced.

On the contrary, in many cases, it can often have perverse effects. Since there are cost limits in the Medicare program, if a provider finds itself over the cost limits, due to inefficiency, one way to get under the cost limits is to find ways to increase utilization and average down that cost per unit. That is a perverse effect of the system, and it has many problems. It increases cost and utilization.

The CHAIRMAN. You are one of the six-person working group representing your industry. Give me your ideas as to how prospective payment will work in your industry. Of course, you have been experimenting with it anyway, but give me your ideas as to how it will work.

Mr. HOFFMAN. The way our work group put the plan together, first of all, it takes account of the problems associated with cost reimbursement. It recognizes the need for savings in the program. And we believe that an episodic system is ultimately the best approach.

The CHAIRMAN. A what? An episodic?

Mr. HOFFMAN. An episodic system for home care if ultimately the best approach. Payments per-episode, we believe, is ultimately where you want to be.

Senator MOYNIHAN. Now, help us. What is an episode?

Mr. HOFFMAN. An episode of care. When a patient is admitted for a particular diagnosis, or for a particular span of illness, payment for an episode of care.

In the ABT demonstration project, the episode is defined as a period of time span.

The CHAIRMAN. As opposed to a fee for service. Every time they come in, here is $20.

Mr. HOFFMAN. That is exactly right.

The CHAIRMAN. Basically, it is the managed care approach. We will give you $500 for this episode.

Mr. HOFFMAN. It is exactly the managed care approach.

The CHAIRMAN. Give as much or less care as necessary, but you get $500.

Mr. HOFFMAN. It is similar in concept to the DRG's.

The CHAIRMAN. Yes.

Mr. HOFFMAN. However, the way the industry is structured today, it is not accustomed to that. There is not a real good wealth of data on structuring episodic payments.

So what we have constructed is a methodology which combines the advantages of the current system, which is per-visit reimbursement, with episodic caps, which provide utilization control built into the system.

Providers would be reimbursed at a regionally-set rate, on a per-visit basis. But, depending on what type of an episode was involved, the reimbursement for that episode would be capped at some level, which would also be regionally determined, and the case mix adjusted.

Providers would have the incentive to provide efficient care because, to the extent that they come in underneath those episodic caps, there would be a savings-sharing provision, whereby providers would be able to realize up to 40 percent of that savings.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. We have to find simpler or less coded words. What would anybody who is listening to us think about our going on about OBRA '83 and TEFRA '92, and all these condensations which help, but not necessarily?

Episodic care. It sound like something——

The CHAIRMAN. It sounds like a miniseries. [Laughter.]

Mr. HOFFMAN. I think it is turning out to be that.

Senator MOYNIHAN. It has the virtue, I suppose, of being a word of Greek origin. Hippocrates would have recognized it.

Mr. Chairman, I want to report to you that I have a note here from Dr. Joseph Stiglitz, who is Chairman of the Council of Economic Advisers. Something is happening. In the last 6 months, we have had a price increase, our celebrated CPIU, growing at 3.2 percent a year, and the medical price index growing at 3.7 percent. It is sort of rampaging out of control. Something is working out there.

I wonder if I could just ask the panel—anybody could volunteer if they like—we are talking about restructuring and some kind of voucher program, and I expect you are all familiar with the Federal Employees Health Benefits Plan. What would you think of trying to put Medicare into an arrangement of that sort, where an individual bought insurance, picked a plan which had variations according to pertinent individual needs, or even preferences?

I do not see any enthusiasm. Mr. Aitchison?

Mr. AITCHISON. Senator, I think that, as I mentioned in my remarks on managed care, that would be a possibility, providing up front that a participant, a Medicare beneficiary with that opportunity, so to speak, were presented with information, and they were knowledgeable consumers.

Unfortunately, when a consumer is addressing the question of health care, they do not always know. And, in our small segment of health care, rehabilitation, you always sort of think it is going to happen to the other guy. Four hundred thousand people are a lot in numbers, but it is a small percentage. People do not think they are going to have a head injury, a spinal cord injury, or a stroke, or whatever.

So it is very important, in my opinion, that if that is done, you have an up front statement as to what the benefits will be, and make sure that those consumers are knowledgeable.

Senator MOYNIHAN. Well, you would assume that that would be the objective. But I do not know how knowledgeable anybody is.

Mr. AITCHISON. I will give you a personal example. It is a managed care situation. In New Jersey, we do not have a high degree of penetration in managed care. We recently had a patient, a resident of Arizona, who was in our area, suffered an incident causing admission to our facility. We contacted the HMO to make sure that coverage for rehabilitation care was provided. The answer came back, yes, and the services were provided. The end of the story is that, when the time came for that HMO to pay for those services, they denied payment. As a consequence, our only recourse was to go back to the patient and they, of course, in turn, back to the HMO.

Our concern simply is that this happens too frequently which, obviously, none of us would want. So we do not want to see managed care be a way of denying the benefits.

Senator MOYNIHAN. Well, no. What you are talking about is a malfunction of the system.

Dr. WILLGING. I do not know, Senator Moynihan, whether the solution is a voucher. I do however, support any system which will take us closer to letting the market set prices and determine supply and demand. Once a year—if not more frequently—we all come together, you on your side, we on our side, and we essentially try to control the market. We set prices, we determine supply and demand. I think these are things best left to the market itself.

Now a voucher, if it is begun with an arbitrary determination as to price, whatever it might be, how many thousands of dollars per person, per year, I am not sure that is really letting the market make those determinations.

But certainly, I think we are all frustrated, sitting around these tables year after year, trying to do what the market does better than we do.

Senator MOYNIHAN. Well, thank you. Mr. Chairman, I could not say it as well. There are just inherent limitations on administering systems, and you see one right there in front of Dr. Sundwall with his visual aid.

Dr. SUNDWALL. There is a better way. The debate has moved a great deal. Did you see the Washington Post editorial this morning?

Senator MOYNIHAN. Yes.

Dr. SUNDWALL. The lead editorial was talking about vouchers, and encouraged their serious consideration. Can you imagine? That would have been unheard of just a few years ago.

Senator MOYNIHAN. Could I just take one more second?

I happen to be a dear friend of Mr. Reeve's father. How is he doing?

Mr. AITCHISON. I am not first-hand close to him, and I cannot say very much, Senator.

Senator MOYNIHAN. Please wish him well.

Mr. AITCHISON. I will wish him well for you. He is in very good spirits. He has a lot of support, and is a very motivated gentlemen. I think he will do well.

Senator MOYNIHAN. Good. Thank you.

The CHAIRMAN. Based upon Dr. Sundwall said about vouchers in the Washington Post, there may be some hope for tuition tax credits. [Laughter.]

Senator MOYNIHAN. Well, why not?

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

Mr. Chairman, I apologize for——

Senator MOYNIHAN. Think of our efforts in the 1970's, which people would kill for today.

Senator GRAHAM. Mr. Chairman, I apologize for my late arrival.

I would like to ask questions in two areas. First, the managed care area. The budget resolution which has been adopted calls for a reduction in expenditures below what would otherwise have been anticipated in Medicare of approximately $270 billion over the next 5 years.

What proportion of that do you think can be accomplished through managed care or other systemic alterations in the Medicare system?

Not to answer the question, but to give you someone else's opinion, yesterday Ms. Gail Wilensky, the former head of HCFA, indicated that she thought the range was in the 20 to 25 percent category.

Mr. AITCHISON. That is a huge number. The way I understand managed care——

Senator GRAHAM. Which is the huge number? $270 billion or 20 to 25 percent?

Mr. AITCHISON. Twenty to 25 percent.

Mr. HOFFMAN. Both are big.

Mr. AITCHISON. The way I understand it works is that a managed care entrepreneur would seek to enter this marketplace because they would offer to Medicare a percentage savings from the current costs in that particular area. And they, in turn, would go out and beat up the providers, if you will. And, frankly, they would beat up the beneficiaries to effect those savings.

If you look through that to the profits of managed care, I think you will find them to be substantial. In New Jersey, we have a list. And the top of the list is a profit basis of about 25 percent—23 percent, to be specific—on a book of business in the neighborhood of $890 million.

So, clearly, there are savings. That is an example on the high end. I think with 20 to 25 percent, you are going to hear from your constituents. I believe there is going to be some significant pain with that degree of cut.

Senator GRAHAM. Would you care to venture an estimate, or can we just put you down as less than 20 to 25 percent?

Mr. AITCHISON. I would suggest less than 20 to 25 percent. But there are savings possible there. There is no question about it. And we all should be for that.

Senator Moynihan was talking about price increases. In our particular facility, for example, we have not increased fees for the past

4 years, none, zero. And that is a factor of this marketplace, where we are all trying to cut costs and be competitive.

Senator GRAHAM. You mentioned that New Jersey does not have a very extensive managed care system. Is that correct?

Mr. AITCHISON. That is correct, not a high penetration.

Senator GRAHAM. Well, what would your penetration level be in New Jersey?

Mr. AITCHISON. It would be a guess, Senator, but it would be in the 5 to 10 percent range for Medicare beneficiaries. For other patients, we have seen a significant increase. Of those patients coming to us who are non-Medicare beneficiaries—the commercials, if you will—we have seen that number jump, double, in the past couple of years. It is in the neighborhood of 35 to 40 percent at the moment. And I think it will go up substantially more, probably another 50 percent.

Senator GRAHAM. Why is there such a gap between the penetration level of Medicare beneficiaries and the rest of the population?

Mr. AITCHISON. The general feeling in our area is that the regulatory environment of New Jersey has suggested that it is not a good marketplace for the managed care population. That has tended to lighten up under the current administration, and I think you are seeing more HMO's seeking to do business in our State. So I fully anticipate that there will be more managed care in New Jersey, more directed at the Medicare beneficiary population, and consequently a higher percentage overall.

Senator GRAHAM. Would any other members of the panel like to comment as to what they think is the proportion of this reduction below expectancy in Medicare that can be accomplished through systemic changes, such as increased utilization of managed care? That is not the only system change. If you would like, please suggest others, and put a number behind them as to what you think they can contribute toward achieving this goal.

Mr. HOFFMAN. I would agree that 20 to 25 percent is a rather high number. However, I would bring to your attention, Senator, that for the small part of the world that is covered by the home health industry, the plan that we have put forward begins to get close to those percentages.

And I would also hasten to add, I believe in yesterday's testimony, Dr. Wilensky indicated that, in her view, there were basically two ways to control costs. One way through providing incentives, and another is through regulation. And, speaking for myself, I believe that incentives is by far the more efficient and productive way to go.

Senator GRAHAM. My time is up, so if you might just give a number, with a brief explanation.

Dr. WILLGING. Well, probably, if we are willing to recognize what managed care is, I am willing to give you a rosy scenario that says it is higher than 25 percent. Bob Blendon, Professor Blendon from Harvard, during the course of health reform debate last year, made one of the most trenchant statements that anyone has made. The problem with health care costs in this country is not the price of aspirin, it is how much aspirin we consume.

As long as we recognize that what managed care really means in its ultimate permutation is not merely continued price discount-

ing. As I said, we can only get so much blood out of those turnips. The issue is, is somebody eventually going to say no? No, you cannot have that MRI, a CAT scan will be sufficient, or perhaps an X-ray. No, you do not need that extra day in the hospital. No, you do not need to receive that service in a hospital; you are going to receive it in a subacute unit.

Somebody has got to say no. The question is, will anyone say no? Who is going to say no? And will the American public accept that?

But if you indeed go from price discounting under managed care to truly managing care, yes, you can in fact achieve considerable savings. I do not know what percentage that is. I think it can be higher than the 25 percent that Dr. Wilensky suggested.

Senator GRAHAM. Do you think most of the reductions that have occurred thus far in the private sector, that were cited earlier, have come because of price discounting, as opposed to managing care?

Dr. WILLGING. I believe, yes. And, in fact, people such as Jay Greenberg, who is in charge of the long-term care division for United Health Care, says that is how almost every managed care entity, at least in the initial stages of its successes, has saved the money—discounting prices, getting the hospitals to reduce the price, the physicians to reduce the price. It is when you go into true managed care, that you begin to sense the difficulties.

We have seen a little bit of that controversy just over the last couple of weeks. Is one day of postpartum care sufficient for a new mother? Or should we allow more than that? I do not know where the balance is. But that is where the real political difficulties begin to come in.

Senator GRAHAM. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Sundwall, you indicate that cost-sharing will not produce any savings. Of course, CBO says $7 billion in savings. Where are they incorrect?

Dr. SUNDWALL. Well, I think that is a budgetary figure that they are extrapolating. Over 7 years, if you take 20 percent copayment, that is the figure they get.

Unfortunately, I do not think they are going to achieve that. They are counting on some reduction in services, which we do not think will happen. We do not think people will decide, gee, I had better not get a postatic antigen test (PSA) because I will have to pay $10 or $15. If it is in their interest to have this test, I think the doctor is still going to strongly recommend it.

Of course, our objection is not only that we do not think you will recoup the savings you anticipate, but that we will not be able to get our copayment. In fact, some studies estimate that our inability to collect these small copayments could be as high as 80 percent. And you can imagine the seniors' frustration with getting a bill from someone they have never heard of—maybe from an out-of-State lab—and then going to their doctor and saying what the heck is this all about, or going to HCFA and asking what are you doing to me?

It is an annoying way to get at some savings. We think there is a better way to do it. And we are certainly prepared to work with your staff to find additional savings from clinical laboratory services. But it would be less regulatory, less onerous, and not annoy the beneficiaries so much.

The CHAIRMAN. Let me ask you this projected question. You indicated that expenditures for independent labs have gone down between 1993 and 1994, which is correct.

But both CBO and the Health Care Financing Administration are predicting 9 to 12 percent increases, but they are counting all labs, of course.

Now we have three basic kinds of labs, do we not? We have your labs, we have hospital outpatient, we have doctors' labs. Even if your costs are staying stable, are those other costs escalating that rapidly in the other two kinds of labs to make up that kind of a difference?

Dr. SUNDWALL. It is hard for me to believe that their charges are going up. I have to wonder if it is volume.

The CHAIRMAN. Volume again?

Dr. SUNDWALL. I certainly do not think it is cost-per-service. Like Paul said, it is the demand for those services.

And I can only speak for the independent labs. I know our data, and I do not know how they arrived at the figure for the total. But I do know, both for doctors' offices and for independent clinical labs, the expenditures seem to be on the decline. Even the Medicare trustees' report suggested that the cost per beneficiary was going to go down slightly in their projected years.

I am always a bit nonplussed or perplexed by these out-year projections, but they say that they will be less than they previously anticipated. And we think the CBO figures will reflect this when they do their analysis, based on their own new information.

The CHAIRMAN. Mr. Aitchison, you mentioned that New Jersey is not a favorable climate for managed care. Is that because of some State anti-managed care prejudice?

Mr. AITCHISON. No, I do not think so at all, Mr. Chairman. I was just pointing out that the general statement as to why New Jersey has not been a popular place for the HMO companies to enter, for purposes of serving the Medicare beneficiary, is because of regulation.

I think, in today's environment, just the opposite is occurring. As the regulation decreases, and as the receptivity for managed care has increased, they see this as an opportunity to indeed penetrate a market, and make substantial dollars.

The CHAIRMAN. I will give you some figures again, and they always stun me. We love to look at our own States, and I have indicated before that Oregon had a long history with the Kaiser health plans because of the shipyards that were built during World War II. Kaiser, at the zenith, employed 30 percent of the adult labor force in the Portland area, and they were on the Kaiser health plan.

But Blue Cross-Blue Shield moved into managed care some time ago. They saw the handwriting on the wall. And this is how fast their total coverage has grown. In 1984, they had none, zero, zip managed care. Five years later, in 1989, 43 percent of their coverage was managed care. Five years later, in 1994, 66 percent. And they are projecting that, by 1998, that 90 percent of their coverage is going to be managed care.

When the fetters are off, it just grows immensely. And these figures are 1994 January. By January of 1994, the entire Portland

metropolitan area had reached 63 percent managed care coverage. And my estimate is that it is between 70 and 75 percent now.

Mr. AITCHISON. Yes. Those numbers do not surprise me. In fact, I think the Blues have made a concerted effort to move toward managed care. In our state, the flat-out statement by the CEO of Blue Cross is, we no longer will offer an indemnity program. So you do not have a choice. You are naturally going to have the population gravitate to a managed care product, if that is the only one available.

The CHAIRMAN. I remember, Pat, that wonderful dean of the UCLA Medical School—it is a complex now. That is the same one that talked about the spot market.

Senator MOYNIHAN. Yes, the bone marrow transplants.

The CHAIRMAN. He said there is no indemnity insurance left in Southern California. The only time we see it is if somebody from Iowa has an automobile accident in Southern California, and they are covered by an indemnity carrier. He may have overstated it a bit, but not by much, I think.

Senator Moynihan? Oh, I did not see Senator Grassley over there. I apologize, Chuck.

You are on.

Senator GRASSLEY. I have a question of you, Dr. Sundwall. And it is not related so much to the immediate cost containment that we are trying to adopt for the immediate budget resolution, but probably for years beyond that, and directly related to the impact of CLIA.

I have had a lot of relatively small laboratory people express to me fear that large laboratories are buying up so many of the smaller ones, or expanding their business, that we are going to have just a very, very few laboratory organizations or corporations doing this sort of work in the country. And, at that point, there is not going to be enough marketplace competition to keep the price down. Then, when these little people are gone, we really have to fear skyrocketing costs on laboratory services. Do you agree with that? Is that something we need to be concerned about, or is that an erroneous statement that was made to me—statements, because there was more than one statement made?

Dr. SUNDWALL. Senator, let me explain to you what I understand of the clinical laboratory industry. Over recent years, it has undergone a remarkable consolidation. Like other components in a free market society, there has been a real shakedown, or shakeout, of corporations merging, downsizing, what have you.

We have witnessed this in the clinical labs. We now have as members of the American Clinical Laboratory Association only 11 members—that is, 11 companies that we represent—but which in turn own about 700 facilities in all States of the Union. And these 11 companies compete fiercely with each other. And I would say that there is a very healthy market economy in labs right now. And this results in tough competition.

So smaller labs that do not have the economies of scale of larger companies are threatened. I think they have serious competition, but my view right now is that this represents a very healthy dynamic. And it certainly is passing on savings to payors and patients.

I think the reductions that we have seen in the numbers of labs are because of a market that is working. If we could get rid of some of the regulations that I referred to, which are burdensome and costly, unnecessarily so, market forces could work even better.

But I understand the concerns of the small lab. We are sensitive to antitrust issues, and we have to be aware of those legal concerns. I do not think we are anywhere near that now, but I understand why you have heard of concerned.

Senator GRASSLEY. Well, we wrote a Federal law on clinical laboratories a few years ago that led to the closing or sale of a lot of small laboratories. And so we have less competition as a result of that, and that is not a very good situation. We are impacting the marketplace, and we should not be doing that.

Dr. SUNDWALL. Well, are you suggesting CLIA?

Senator GRASSLEY. Yes, that is the legislation I am talking about.

Dr. SUNDWALL. I do not think I would agree that CLIA is the factor. I think it is more competition in the whole health care arena—managed care, contracts, the whole thing.

Let me just give you a personal experience. As a young doctor in practice, I had vendors of technologies and machines come to me saying, gee, you ought to buy this and put it in your office. You can add thousands of dollars to your income every year if you will just do your own tests. I tried one for a month, free of change. When I had concerns about the quality, they said, oh, do not worry. We will come and check your reagents to make sure it is a good machine.

However, I had absolutely no confidence in those tests. So I then sent all my lab tests out to an independent lab because I felt they were more accurate. It was less income for me, but I thought it was better value for the patients. And I did not charge them anything for doing that.

I think that doctors' offices being regulated by CLIA, along with smaller labs, has raised the overall level of quality, which is good. Labs should all be subject to the same kind of quality controls. I do not know how much you are willing to give up, in terms of quality control, in return for addressing concerns about the market. I think it is really more an issue of protecting patients' interests and the data provided from their lab work.

Senator GRASSLEY. We had an inspector come to a very small county hospital in my State within the last 6 months, spend a whole day there, taking up the time of all the people who are involved in the supervision of a relatively small laboratory associated with it.

There were some concerns, not very major ones. But the bottom line was that it really does not make any difference anyway, because we are going to write all these new regulations.

Now that is just a comment on what we are doing with existing law, and the cost of hospitals, and the time consumed by the investigation.

This is not about the immediate costs we have here. But it seems to me that we are going to have to look and see if CLIA is working the way we intended it to work. And I have not drawn any conclusions yet, but I hope it is something that not only myself but the

staff of this Committee would be interested in, and at least have a questioning eye.

I do not think I am in a position to imply that anything is wrong, except maybe a Federal law has had an inordinate impact upon smaller laboratories and larger laboratories.

Dr. SUNDWALL. Well, we would certainly be interested in working with you on CLIA issues.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, I would just like to make a general comment about where I think we might want to be moving.

In response to a question by Senator Graham, Dr. Willging told us that somebody is going to have to say no. Well, if that somebody is an official, they will not say no. Or, if they do, it will be accompanied by huge resentment. That is what markets do, because they diffuse that kind of decision.

And I just would say, Mr. Chairman, if the United States Government administered the income tax system, could you imagine if we had a Government official decide how much everybody in this room would be taxed? We have an extraordinary self-assessed tax system. We have, what, about 110 million tax returns a year? And people figure it out on their own, they decide how much they owe the Government, and they send it in.

If have heard some troublesome things about the new inspection, but we do keep a quality control. Last I knew, there is a percentage of people who get it wrong, but the number of people who overpay is about equal to the number of people who underpay. The number of people who deliberately try to evade taxes is not high. For all you hear, we trust the system.

Now that works. I think what we put in place with Medicare and Medicaid set some administered decisions that we do not have enough skills to carry out. Is it not something like that, Dr. Willging?

Dr. WILLGING. Well, when I say that someone has to say no, we get to a dirty word that no one wanted to use last year in the health reform debate. It started with an R—it is called rationing.

The issue is not whether health care would be rationed, if you are going to save on costs. That was not the issue. The issue was who is going to do it? Is it going to be you and me, in terms of our market-based decisions as to what kind of health care package we are going to buy?

Or, as you say, Senator, is it going to be an official in Washington, DC? To me, that was the essential nature of the debate. If we wish to save on health care costs, I get back to Bob Blendon. It is not the cost of the aspirin, it is how much aspirin we consume. And, if you want to get to the point of reducing the costs, somebody is going to have to consume less aspirin. Personally, as a consumer, I would rather be the one to make that choice.

On another program that this Committee has responsibility for, called Medicaid, there had been a lot of discussion about long-term care insurance as a way to begin to shift the burden off the public sector. But the minute we got into it, we had tons of people telling us how the product should look. We ought to mandate this, we ought to mandate that, non-forfeiture, inflation adjustment.

We were determining the product and the price. And, whether we like to admit it or not, we end up also then determining the viability of that very product or price, because we start to make decisions that the market should make.

What I say is perhaps not very popular. I have been chastised a number of times by my own members for being somewhat more open than I should be. But I think that is what it really gets down to.

We should look at other things. Obviously, we should look at fraud and abuse; it exists, we have got to ferret it out. But, ultimately, the big cost savings are going to come from true managed care, with people deciding yea or nay in terms of a basic service. And, again, the issue is who says it?

Senator MOYNIHAN. Well we have some——

Dr. WILLGING. It should be the consumer, not the Government.

Senator MOYNIHAN. Well, we ration the number of trips people take to Disney World. [Laughter.]

Dr. WILLGING. And we do it ourselves, do we not?

Senator MOYNIHAN. But you do not have to get a coupon. Something like that, Mr. Chairman. I think we are moving that way, are we not?

The CHAIRMAN. You can get coupons for Disney World? [Laughter.]

Dr. WILLGING. I think we need a Government bureaucracy to handle that. How many coupons do you get for Disney World this year?

Senator MOYNIHAN. Yes. Well, if you left it up to me, everybody would get five. I am the friend of the American family.

The CHAIRMAN. Senator Graham would agree with that.

Senator MOYNIHAN. That is right.

Senator GRAHAM. That is a woefully deficient number. It would cause psychic distress and downstream health problems to literally millions of Americans. [Laughter.]

Senator MOYNIHAN. I think we have just illustrated a very important thought experiment here.

Senator GRAHAM. No one has ever accused Senator Moynihan of being Santa Claus.

I would like to follow the comment that you just made, Dr. Willging. And, if I could use a personal example. My daughter has just gone through a wonderful, but somewhat difficult, pregnancy, which resulted in my becoming the grandfather of three little girls at one time. And I happen to have a picture of my triplets here, if you would like to look at them.

Because these triplets were born somewhat premature and underweight, they had a period in the hospital of 3 weeks plus. Then, when they came home, they were on various monitoring devices, which the obstetrician had recommended.

They are under a managed care plan, a plan from the Fairfax County school system, where my daughter had been a teacher. And the HMO denied some of the costs which had been associated with this technology.

It struck me as being a rather unfair situation, in that my daughter was in no position to make an informed judgment as to whether this technology was or was not appropriate. She was rely-

ing on professional expertise. And then, after the fact, to have these services denied coverage will impose a not inconsiderable financial burden on them, for what they thought was a covered service.

So, is the statement that we ought to let customers decide, is that reality in this process? They are going to depend upon an intermediary which, in this case, is the HMO. And they are going to be essentially transferring their judgment to that HMO, and have to have some expectation that the HMO is going to be operating in their health benefit.

And I might say that this is somewhat of an isolated situation, because their general experience has been extremely positive with this HMO. But how do you protect the user, particularly when we are talking about the elderly, who are often less able to protect themselves than my daughter and her husband?

Dr. WILLGING. I think it is not isolated. I think it is true that no system is ever going to function perfectly. And I have experienced the same problems. I have been a member of an HMO, the Columbia Medical Plan, since I first came to Washington 26 or 27 years ago.

As recently as the other day, my wife was ranting and raving—and my wife can truly rant and rave—about a decision made in terms of one of my daughters, and whether she should or should not see a dermatologist for a problem she had.

I think that system is at least closer to the consumer, if you have appropriate appeals mechanisms. I would probably rather do battle with the HMO, recognizing all of the downsides, the uninformed consumer and so forth.

But I would rather do battle with the HMO than with the Health Care Financing Administration any day of the week. Three thousand miles away, conceivably, if they even answer their phones, is not the kind of close to the consumer relationship that I think can be fostered as you move it down the pike, down the stream, closer to the consumer.

Will we still hear stories, lots of stories, about what appear to be inappropriate decisions by managed care entities? I suspect we will. But I would close simply by referencing the statement you made at the close of your remarks. In sum, however, we have been very happy with the kind of general care we have received over the last 26 years, even though we will rant and rave on occasion.

Senator GRAHAM. Are there any provisions that you think should be incorporated into the Medicare legislation that we will shortly be considering, in the context that we are expecting a larger proportion of Medicare beneficiaries to be in managed care, in order to insure that the care is of appropriate quality, and that they have some redress when the standards of quality are not met?

Dr. WILLGING. I think those who study competitive markets do make it quite clear that one of the critical aspects of any truly competitive market is information. You have got to have a system which provides adequate information to the consumer to be able to make appropriate decisions.

And that information has got to include understandable benchmarks of quality, certainly not the way we assess quality today, but true benchmarks that the consumer can understand.

With those two factors involved in a managed care operation, I think we can forestall a lot of the abuses that might otherwise crop up.

Dr. SUNDWALL. Senator, could I just add to that?

Senator GRAHAM. Yes.

Dr. SUNDWALL. This is an unsolicited plug for a Federal effort which I fear is in jeopardy. And that is the effort on the part of the Agency for Health Care Policy and Research to promote guidelines of care and clinical practice guidelines.

Apparently, that agency has been targeted underfunding, if not undoing. And I think that effort is very valuable in encouraging appropriate utilization of services. Those guidelines are not intended to be a recipe for care, but really just guidance to clinicians. And I think that is a very nice adjunct to your restructuring Medicare, for the Government to encourage that kind of development of clinical practice guidelines.

Mr. HOFFMAN. If I might chime in there as well, I think back in the old days in health care, the credo was quality at any cost, and care at any cost. Clearly, that formula has not worked.

But we cannot run the risk of going to the other end of the spectrum completely, and feeling that the only thing that matters is cost. We need not lost sight of quality and, in any system, there must be measures taken to assure quality.

Senator MOYNIHAN. Mr. Chairman, there is a vote.

The CHAIRMAN. I see that there is.

We are going to have to terminate this here. I think we have pretty much finished the questions, have we not? We apologize for running out. We have about 5 minutes left to make the vote on the floor.

Gentlemen, thank you very much. We are adjourned.

Senator MOYNIHAN. Thank you very much.

[Whereupon, at 10:50 a.m., the hearing was concluded.]

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APPENDIX

Additional Material Submitted

Prepared Statement of Kenneth Aitchison

Mr. Chairman: My name is Ken Aitchison. I am President of Kessler Rehabilitation Institute in West Orange, New Jersey. I am appearing today on behalf of the American Rehabilitation Association, which is the principal national membership organization of rehabilitation facilities.

The American Rehabilitation Association (formerly NARF) is the largest not-for-profit organization serving vocational, residential and medical providers in the United States. The established leader in the field of rehabilitation for more than a quarter century, American Rehab serves its more than 800 member facilities by effecting changes in public policy, developing educational and training programs, and promoting research. In addition, it provides networking and communications opportunities, all of which help to ensure quality care and access to services to more than four million persons with disabilities each year.

I have worked in medical rehabilitation for almost 30 years, having served as executive director of the rehabilitation hospital of the University of North Dakota for a number of years before coming to Kessler in 1979. Over this period I have had the opportunity to chair both the Rehabilitation and Chronic Disease Section of the American Hospital Association and the Commission on the Accreditation of Rehabilitation Facilities. The hospital where I work is one of the largest freestanding rehabilitation hospitals in the country with 320 beds. Most of these are from northern New Jersey and other parts of the New York metropolitan area, but because of the range of services we provide, patients come to us from all parts of the country. As an example, the actor Christopher Reeve is now in rehabilitation at Kessler.

I understand the subject of this hearing to be the options for changes in Medicare payment policy for medical rehabilitation, including particularly the implications for rehabilitation services of higher rates of Medicare enrollment in managed care plans.

Medical rehabilitation addresses itself to a single end—the elimination or mitigation of disability. We seek to restore a person's ability to live, work and enjoy life after an illness, trauma, stroke or similar event has impaired his or her physical or mental abilities. Most patients enter rehabilitation after an acute hospital stay. In 1994 about 400,000 people per year received such services as inpatients in rehabilitation hospitals or rehabilitation units of general hospitals. Many more receive such services as outpatients. There are about now 200 rehabilitation hospitals and 800 rehabilitation units in general hospitals.

Many of the conditions requiring rehabilitation services are associated with advancing age, particularly strokes, arthritis and orthopedic conditions. Accordingly, a relatively high percentage of the persons who need rehabilitation are covered by Medicare. In 1994 about 71% of discharges from rehabilitation hospitals and units and 66% of total days of care were covered by the Medicare program. These figures do not include Medicare beneficiaries who have chosen to enroll in managed care plans. Thus, rehabilitation facilities are perhaps more affected by Medicare policy than any other element of health care.

My statement will address two issues—reform of current Medicare payment policy for inpatient rehabilitation, and protection of patients who opt for managed care in lieu of traditional Medicare.

I. MEDICARE REFORM

A PPS for Rehabilitation is Badly Needed

Rehabilitation hospitals and units are excluded from the Medicare PPS and are paid for services to Medicare patients on the basis of reasonable cost, subject to per-discharge ceilings imposed under TEFRA. TEFRA limits were imposed in 1983 as a temporary measure. They make no sense and seriously distort the delivery and cost of hospital rehabilitation services. Because HCFA routinely allows new providers much higher limits than older ones, the construction of new hospitals and creation of new units is encouraged. There are about four times as many rehabilitation hospitals and three times as many units now than when TEFRA limits were introduced. Because reimbursement caps are based on historic cost, there is a very strong incentive to reduce length of stay and a bias against taking complex cases. large incentive payments are being paid to new hospitals while older facilities lose money on Medicare patients.

While some providers are helped and others hurt by this irrational system, no one (including HCFA) defends it. In 1990 the Congress directed HCFA to submit recommendations for reform by April 1992. Nothing has been forthcoming.

To try to fill this void rehabilitation providers funded research to design a patient classification system to serve as the basis for a PPS for rehabilitation. This work was done at the University of Pennsylvania and was highly productive. There now exists a system of 60 classifications that include almost all Medicare patients. These classifications, known as functional related groups (FRGs), predict the duration and intensity of rehabilitation services based on a patient's age, diagnosis and functional abilities on admission. In other words, they do for rehabilitation patients what DRGs do for patients in acute care.

This system exists. HCFA is in the process of awarding a contract to design a payment system.

Adoption of a payment system whereby hospitals are paid based on the types of patients they treat is badly needed. It will eliminate the incentive in the present system to develop new hospitals and units (adding ever more cost) and compensate all providers based on services provided rather than the completely arbitrary and inequitable TEFRA system. Most importantly, a PPS for rehabilitation would eliminate the most corrupt element of the present system—the explicit message to hospitals to avoid severely disabled patients.

A PPS for rehabilitation, even if budget-neutral upon adoption, would result in considerable savings to the Medicare program as the perverse incentives of the TEFRA system are eliminated. In the short term some providers of services—perhaps even my own—would receive less in Medicare payments. But payments based on patient need can only serve the legitimate interests of both hospitals and patients over the longer term.

We ask this committee to set a date certain for adoption of such a system. In the absence of such a legislative mandate, the 12 years of "temporary" TEFRA limits can easily stretch to 15 or 20 years with injury to patients and the Medicare budget.

We urge that a PPS for rehabilitation based on the FRG system be required for fiscal years beginning on and after October 1, 1996.

Revision of Definition of a Rehabilitation Hospital and/or Unit

We also recommend that the Medicare Act be amended to include a definition of a rehabilitation hospital and/or unit. Currently, the definition is controlled by regulation. The rehabilitation field has been trying for several years to obtain revision of this definition to reflect current practices. HCFA has done nothing.

Our principal concern is this: to qualify as a "rehabilitation hospital" or "rehabilitation unit" under the present definition, an entity must have 75% of its discharges in 10 diagnostic categories. These are based on the treatment patterns of 20 years ago. To meet this standard some hospitals and units have to restrict admissions of certain types of patients who otherwise meet all criteria for service. We believe that four diagnoses now common in rehabilitation facilities should be added. These are pulmonary, chronic pain, cancer and cardiac.

Language to effect this change has been provided to the committee staff.

Rebasing TEFRA Limits for Long Term Care Hospitals

We recommend one further Medicare reform: basing TEFRA limits for long term care hospitals on current cost.

The FRG system we recommend be adopted for a PPS for rehabilitation does not cover chronic care patients, those often served by long term care hospitals. It is not, therefore, possible to include these institutions in our proposal of a PPS for rehabilitation.

Nonetheless, TEFRA limits have the same inequitable and distorting effects for these institutions that they do for rehabilitation hospitals and units. Accordingly, in lieu of a PPS for this class of providers, we recommend that TEFRA limits be based on current costs.

II. BUNDLING OF REHABILITATION WITH ACUTE CARE IS A POOR IDEA

From time to time, it has been suggested, most recently in several House budget documents, that rehabilitation services should be "bundled" with DRGs. I want to take a minute to tell the committee why this is a very poor idea.

In addressing this matter I assume that "bundling" means increasing a DRG payment and making the DRG provider responsible for rehabilitation service. Presently the DRG payment covers only the acute stay, and the provider of rehabilitation is paid separately.

The main reason to oppose bundling is its potentially adverse effects on patient care.

Acute care medicine is addressed to the immediate medical condition of patients. It focuses on the pathology and chemistry of a given diagnosis. Rehabilitation is concerned with the patient's ability to function—to perform the daily activities of living, working and otherwise enjoying life. For example, in the acute phase, a physician attending a stroke patient is concerned with reducing cranial swelling and the potential for another CVA through drug therapy. Rehabilitation of the patient would center on restoring or improving his or her ability to walk, talk, use his or her arms and legs and adapt to any residual limitations of these functions. This is done through the interdisciplinary provision of physical, occupational, speech and other therapies, as well as psychological counseling to deal with the depression that often accompanies newly experienced physical disability. Rehabilitation also involves working with families and others who are affected by the patient's condition and whose response is likely to affect the patient's progress.

Good medical practice calls for the coordination of these different types of services, but in concept and philosophy they are quite different.

The fundamental problem with bundling rehab into DRGs is that it creates a conflict of interest for acute providers, who will have a strong financial incentive to deny or abridge rehabilitation services. About 800 hospitals have rehabilitation units, but most do not. The incentive to give short shrift to rehabilitation is particularly telling in the case of a hospital that must refer the patient to another provider for services. Thus, bundling would likely reduce the availability of rehabilitation services and/or encourage the creation of more rehabilitation units, duplicating capacity that now exists.

Further, to my knowledge there is no basis for computing the amounts by which DRGs should be increased for rehab (and/or other post acute services). Such costs vary widely depending on the patient's diagnosis, age, degree of impairment, family circumstances, medical condition and other factors. As noted, a patient classification system for rehabilitation patients has been developed and we hope it will serve as the basis for a PPS. It does not, however, tie to DRGs. Rather, its primary element is the functional status of a patient upon admission to rehab. Thus, any bundling of rehab into DRGs would be extremely arbitrary and therefore harmful to patients.

Finally, there is no current system to monitor whether care is appropriately provided under such a system; in other words, to measure outcomes. Rehabilitation providers are unique in the health care system in that they focus on outcomes—the improved functional capabilities of their patients. A decline in utilization of their services, which would inevitably accompany bundling, would result in a loss of such focus and higher levels of residual impairment and dependency.

For these reasons we believe that bundling rehab into DRGs is a very poor idea. We are, however, in favor of bundling post-acute services and are actively working on a proposal for doing so. Under such a concept, Medicare would make a single payment for all post-acute rehabilitation services for a defined period, perhaps six months. The recipient provider would be responsible for all rehab services during this period. This would eliminate the potential for patients being shifted from one provider to another—rehab hospital, SNF, home health or other outpatient service—without good case management and at high cost.

We hope that such a concept will closely follow in time the adoption of a PPS for rehabilitation.

III. REHABILITATION AND MANAGED CARE

As I have noted, a high percentage of patients treated in rehabilitation facilities are covered by Medicare. It has been suggested that one means of reducing the rate of increase in overall Medicare expenditures is to encourage more Medicare patients

to enroll in managed care. At present only about 9% of Medicare beneficiaries have chosen to move from fee for service Medicare to HMOs and other managed care plans.

This relatively low rate of enrollment obscures the fact that managed care enrollment is much higher in certain part of the country, particularly on the west coast. In California, for example, over 20% of Medicare patients are enrolled in managed care plans. Those of us in other sections to the country look to the experience of our colleagues in the west for enlightenment about the effects of managed care. We have concerns which I wish to share with you.

It is an article of faith among many policy makers that "managed care" is an appropriate way to slow the rate of growth in health care expenditures. Managed care plans, primarily health maintenance organizations, are replacing indemnity carriers as the insurer of choice for many corporations. Various members of Congress are advocating the provision of incentives for enrollment in managed care plans by Medicare beneficiaries.

In concept there are two reasons why managed care plans can provide care at lower cost than traditional forms of insurance and health care delivery. First, it is assumed that by hiring or contracting with providers of services to significant patient populations, HMOs and other managed care plans can achieve economies of scale (or drive hard bargains). Second, through "management" of care through gatekeeper physicians and other controlling mechanisms, they can avoid delivery of ineffective or superfluous services and, thereby, avoid the associated costs.

In fact, there is a third factor, denial of services. Enrollees may find that certain services are not provided, either because they are deemed to be unnecessary or because of contract limitations, the effects of which are not appreciated until it is too late. This observation is not to suggest that HMOs and other managed care plans seek to deceive enrollees, but rather that certain specialty services needed by a relatively small number of people do not receive adequate consideration by either the plan or the enrollee until the service is needed.

About four million people annually receive some type of therapy service. Of these, about 400,000 are admitted to a rehabilitation hospital or a rehabilitation unit in a general hospital. Thus, the chance that any given individual will need rehabilitation services is slight.

This means that it is unlikely that a person shopping for HMO coverage will anticipate the need for and coverage of rehabilitation services. Rehabilitation services are intense and of longer duration that acute care. By their very nature HMOs and other managed care plans seek to avoid or minimize the cost of such services. Our association recently surveyed member facilities and found that many HMOs do not refer patients to rehabilitation hospitals or units. The Medicare Advocacy Project, Los Angeles, California, in its January 1993 report, "Medicare Risk Contract HMOs in California: A Study of Marketing, Quality and Due Process Rights" noted the failure of many HMOs to refer for needed specialty care, including rehabilitation.

For these reasons, we recommend that managed care plans enrolling Medicare beneficiaries fully describe coverage of rehabilitation services and that any limitations on such coverage be clearly delineated. The following principles are recommended for inclusion in any legislation designed to foster the use of managed care plans by Medicare beneficiaries and others.

Plan Information

Plans should provide uniform descriptions of benefits, services and procedures that clearly and fully disclose limitations of coverage, exclusions and out-of-pocket costs, including co-payments, deductibles, coinsurance, and established aggregate maximums on out-of-pocket costs.

Assessment

Patients who have impaired functional abilities from strokes, trauma and other disabling conditions should receive a rehabilitation evaluation by a trained rehabilitation physician or professional. If an enrollee is a candidate for rehabilitation he or she should have access to and be referred for those services.

Quality

Managed care plans should be accountable for the quality of care provided. Plans should report sites of treatment and outcomes, both medical and functional, to the government and to enrollees on a regular basis.

Specialists as Gatekeepers

Enrollees who require ongoing, specialized health services should be able to choose a specialist as a gatekeeper in order to effectively manage the services appropriate to their conditions. Relevant specialists should also be directly available to

enrollees without gatekeeper approval where continued specialized care is medically indicated.

Point-of-Service Option

HMO enrollees should have the right to obtain care from out-of-network providers, assuming they opt to pay any extra costs. This retains the ability of closed-panel HMOs to contain costs, but also allows enrollees the flexibility to opt out of the provider network if they pay a little more for this option.

Consumer and Provider Due Process

Plans should set forth procedures to be followed in the resolution of disputes with enrollees about required services and the adequacy of those provided by the plan. Grievance mechanisms should be timely and fair.

Grievance and appeals procedures should:

(a) be available to both enrollees and providers, including timely review of a service denial;

(b) be clearly communicated to all parties;

(c) require independent second opinions to be obtained promptly when covered benefits are denied for any reason;

(d) require an expedited appeals process leading to a decision within 72 hours of the initial complaint.

Utilization Management Protocols

Utilization review should be performed by qualified personnel knowledgeable in the field in which a coverage decision is being made. Qualified health professionals, including rehabilitation providers and other specialists, should be involved in the development and implementation of utilization review procedures and practice guidelines.

Consistency

Plans should be consistent in the information required, i.e., data elements and methods of analysis, evaluation criteria, assurance of non-discrimination among classes of providers, uniform quality and utilization standards, outcomes assessment, assurance of access, fair and adequate reimbursement, consistency of record-keeping requirements.

Ability to Opt Out

Ultimately, it may be impossible to adequately protect the interests of severely disabled persons requiring intensive rehabilitation services through the types of procedural requirements I have described. We recommend that if such an enrollee is dissatisfied with the type or quality of rehabilitation service provided, then he or she have the option to return to Medicare fee for service coverage, as enrollees can do now by disenrolling from the managed care plan. We recommend that this process be made simpler, be clarified and be included in all plan literature.

IV. CONCLUSION

The actions taken by this committee and this Congress with respect to the Medicare program will have profound effects on persons with disabling conditions. The actions we recommend will preserve and enhance the availability of rehabilitation services to Medicare beneficiaries while eliminating wasteful and inequitable practice under current law.

PREPARED STATEMENT OF STUART H. ALTMAN, PH.D.

Good afternoon, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., Executive Director of ProPAC. I am pleased to testify today as you consider alternative ways to control the rapid rise in Medicare spending. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

MEDICARE SPENDING GROWTH

In 1995, Medicare program spending is projected to be about $178 billion, an increase of about 12 percent over 1994. The Medicare population is growing faster than the general population, and about 2 percentage points of this spending growth can be accounted for by more beneficiaries and their increased age. Inflation in the general economy, as well as additional growth in the price of medical goods and

services providers purchase, also contributes to the escalation in Medicare spending. But there is one other responsible factor that I will return to frequently during my testimony: much of the recent acceleration in expenditures is due to more Medicare beneficiaries receiving more and more services each year.

As the members of this Committee are aware, Medicare continues to be predominantly a fee-for-service payment system. This payment method provides strong incentives for physicians and other providers to furnish more services to beneficiaries who are willing to receive them. Many of these services, however, may be of limited medical value to specific individuals. The private insurance market is responding to this problem by developing alternative payment systems based on capitation and managed care. These methods contain strong financial incentives for providers to control the cost of each unit of service as well as the number of service units furnished. There also are incentives to furnish high quality care since purchasers and their enrollees also consider this factor in selecting among competing plans and providers.

While more and more Medicare beneficiaries are choosing capitated, managed care plans, overall enrollment lags well behind that of the private sector. There are a number of reasons for this, several of which I will discuss in a moment. Today, I am going to focus on changes to the existing Medicare program that might control spending growth in the short term, but I want to emphasize that much of this growth is due to Medicare policies that encourage increases in the volume of services provided, and more fundamental changes in the Medicare program are necessary to correct these incentives.

Over the past decade, the Medicare program generally has done a good job in implementing policies that controlled increases in payments for individual services. The first major change was the shift from cost-based reimbursement for inpatient hospital services to the Medicare prospective payment system (PPS). The effects of PPS and other Medicare policy changes over the past decade can be seen in Chart 1. Between 1979 and 1983, real Medicare spending per enrollee—that is, adjusted for inflation—was growing faster than private health insurance expenditures per insured person. Medicare policies enacted in the early 1980s reversed this trend, with Medicare spending between 1983 and 1991 rising much more slowly than that in the private sector. Between 1991 and 1993, however, Medicare spending growth accelerated, exceeding private sector increases.

Spending increases in settings outside the hospital are a major contributor to the renewed rise in Medicare expenditures (Chart 2). The bulk of Medicare spending continues to be for inpatient hospital services, however, hospital outpatient, home health and skilled nursing facility expenditures are growing rapidly. As I will discuss in a moment, the increase in the number of these services furnished to beneficiaries is a major contributor to this spending growth.

MEDICARE PAYMENT POLICIES

I now would like to turn to a discussion of possible changes in Medicare payment policies in the short term that could alter overall spending growth. There are two broad ways of approaching these changes. The first is to apply an across-the-board reduction in the level of the update factors that determine how fast payments for each unit of service rise. The Medicare program periodically applies an update factor to the base payment amount for hospitals, skilled nursing facilities, home health agencies, and other providers. A similar reduction in update factors for all facilities could be seen as being fair, in that all providers will contribute to the slowing of Medicare spending growth. This approach, however, may fail to recognize the special needs of certain types of providers that Medicare patients rely on. It also fails to recognize that certain types of services are growing more rapidly and may need to be constrained. Accordingly, a second approach could target slowdowns in payment growth to specific groups of facilities through differential payment updates or through refinement of other payment policies that target these facilities.

PPS HOSPITALS

Medicare payments for individual PPS hospitals reflect both capital and operating expenses. For operating expenses, hospitals receive a payment based on the hospital's location and the assigned diagnosis-related group (DRG) plus additional payments if the hospital qualifies. These include special payments to teaching hospitals, hospitals that serve a disproportionate share of low income individuals, and certain rural hospitals. PPS hospitals also receive additional payments for their capital costs and, for teaching hospitals, the direct costs of graduate medical education programs. PPS spending can be constrained by controlling increases in the base payment rate, the individual payment adjustments, capital payments, or a combination

of approaches. The route that you choose to slow spending growth will impact hospitals differentially, depending on their current level of overall Medicare payments and the degree to which they rely on the additional payments. Many of the options that I am going to discuss would affect the same groups of hospitals, and the impact of the total package of spending changes on access to care for Medicare beneficiaries also must be carefully assessed.

Limiting the Increase in the PPS Update Factor

Since the third year of PPS, the increase in the annual update factor has been less than the rise in the market basket index that measures the rate of inflation in the prices of goods and services hospitals purchase. Inpatient hospital payments per case, however, have grown somewhat faster than the market basket as hospitals submitted bills for more complex and costly patients (Chart 3). Until recently, however, hospital costs have grown even faster than PPS payments. By 1990, hospital costs began to exceed PPS payments, and their PPS margins (or profits) became negative in 1990. In 1994, these margins turned positive again, for reasons I will discuss shortly (Chart 4).

The overall financial effect of Medicare's update policies is related to hospitals' ability to reduce cost growth or to obtain additional revenue. Until recently, instead of reducing costs as Medicare (and Medicaid) constrained payments, hospitals responded by increasing revenues from private payers. Between 1986 and 1990, as Medicare payments relative to costs dropped from 101 percent to 89 percent, private payers payments rose from 116 percent to 127 percent of their costs (Chart 5). Hospitals used this extra revenue from private payers to cover losses from public payers as well as the costs of furnishing services to uninsured patients.

More recently, increasing price competition in the health care market place is affecting the ability of many hospitals to obtain excess revenues from private payers to subsidize losses from uncompensated care and government programs. In 1993, private payments relative to costs declined slightly, from 131 percent to 129 percent. Many hospitals are responding to these market pressures by reducing cost growth. Hospital cost growth began to fall in late 1992, and the decline is continuing (Chart 6). Prior to 1993, real hospital costs per case—that is, adjusted for inflation—were growing about 4.7 percent annually. In 1993, this rate dropped to an average of 1.7 percent for the year. This downward trend continued during 1994, and in the first two months of 1995 the change in both real and nominal costs, compared to the first two months of 1994, became negative. This decline in cost growth in large part led to the upturn in the PPS margins.

This dramatic decline in cost growth must be considered as Medicare determines its update policies. Current law sets the PPS update factor at 2 percentage points less than the market basket for fiscal year 1996. The update factor is scheduled to increase by the market basket minus 0.5 percentage points in 1997 and by the full market basket in 1998. If the current cost slowdown continues, the updates scheduled under current law would be higher than anticipated cost increases, and PPS margins will rise substantially.

Consequently, you may wish to continue with an annual update factor at 2 percentage points less than the market basket beyond 1996. You could then examine this factor each year and adjust it further if hospital cost reductions continue.

Currently, the overall financial condition of the average hospital continues to be good, although many individual hospitals are experiencing financial distress. A number of these problem hospitals treat large numbers of Medicare beneficiaries, as well as Medicaid and uninsured patients. These facilities have a limited ability to obtain extra revenues from private payers to cover losses from the care of their other patients. The effects on Medicare beneficiaries served by these hospitals, therefore, must be considered as we examine alternative ways to slow spending growth.

Reducing Differences in Base Payment Amounts

The payment each PPS hospital receives for each case is determined by the hospital's standardized payment amount (SPA) and the relative weight of the assigned DRG (diagnosis-related group), together with certain adjustments and additional payments. When PPS was implemented, there were two standardized payment amounts, one for rural areas and one for urban areas. Subsequently, Congress split the urban hospitals into two groups, creating one SPA for hospitals located in metropolitan statistical areas (MSAs) with populations of 1 million or more (called large urban areas), and another SPA for all other urban hospitals. In fiscal year 1995, the difference between the large urban and the other urban SPAs is about 1.6 percent.

In the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Congress mandated a phase-out of the differential in the SPA between rural and other urban hospitals. This phase-out was completed in 1995. Consequently, there are now only two SPAs, one for large urban areas and one for all other areas. Congress could consider also phasing-out the differential between the large urban and the other standardized amounts. This differential was put in place in the early years of PPS to recognize the slightly higher costs of hospitals located in large urban areas. Since that time, many of these hospitals have benefitted from increases in the disproportionate share adjustment and from the teaching adjustment. Payments to these hospitals account for 54 percent of all PPS payments in 1995 (Chart 7). These hospitals also receive 74 percent of indirect medical education (IME) payments and 63 percent of disproportionate share (DSH) payments. The PPS margin for these hospitals in 1993 was also more than a full percentage point better than that for all hospitals combined (Chart 8). It should be recognized, however, that because of the patient populations many of these large urban hospitals treat, their total margins were less than average.

Reducing Growth in Payments for Medical Education

The Medicare program provides extra payments to hospitals with graduate medical education programs. There are two types of these payments. First, teaching hospitals receive an adjustment to their PPS payments to reflect the added patient care costs associated with operating a teaching program. This IME adjustment accounted for about $3.8 billion in 1994 (Chart 9). Medicare also pays teaching hospitals an additional amount, separate from the PPS payments, for the direct costs of maintaining graduate medical education programs. These payments (referred to as GME payments) cover resident salaries and benefits, the salaries of supervising physicians, office space, and other overhead. The Congressional Budget Office estimates that these payments will total $1.9 billion in 1995. I will first discuss the IME adjustment and then return to GME payments.

The amount of the IME adjustment depends on a hospital's teaching intensity, measured by the number of interns and residents per bed. Currently, payments increase about 7.7 percent for each 10 percent increase in teaching intensity. Each year, ProPAC estimates the relationship between teaching intensity and standardized Medicare operating costs per discharge. The most recent analysis indicates that, on average, a 10 percent increase in teaching intensity is associated with a 4.5 percent increase in Medicare operating costs per discharge.

Since PPS began, the Medicare program has more than adequately compensated teaching hospitals for the costs of treating Medicare patients. In 1993, major teaching hospitals, those with 25 or more interns and residents per 100 beds, had the highest PPS margins of any group of hospitals at 11.7 percent (Chart 8). Their total margins, however, were among the lowest of any group, related in part to the large amount of uncompensated care many of these hospitals furnish. The PPS and total margins for other teaching hospitals were similar to the average for all hospitals.

This year, as we have for several years, we are recommending a reduction in the IME adjustment. We recommend lowering the adjustment in 1996 from 7.7 percent to 6.7 percent for each 10 percent rise in the number of interns and residents per bed. This is equivalent to a 13 percent reduction in the amount of IME payments. This reduction is the first phase of a three-year sequence that would bring the teaching adjustment in line with the amount our analyses suggest is appropriate. We have chosen this phasing approach to allow teaching hospitals time to adjust to the large reduction in payments this would represent. The Commission also is concerned that accelerating price competition in the private sector is reducing the ability of teaching hospitals to obtain the higher patient care rates from other payers that traditionally have contributed to financing the costs of medical education. While we are not suggesting that all of these costs should continue or that all of the current payments are necessary, we believe that this country should also consider an alternative financing system for graduate medical education.

As I indicated, Mr. Chairman, Medicare also pays teaching hospitals a share of the direct costs of maintaining graduate medical education programs. These GME payments are based on a hospital's per resident costs in a base year, updated to the current year. Hospital-specific per resident costs in 1990 ranged from less than $10,000 to more than $100,000. Consequently, Medicare per resident payments also vary widely across teaching hospitals. Payments also differ if the resident is in an initial residency or in a second residency, or in a primary care or specialty program. GME payments have increased in recent years, as the number of residents has grown.

There are a number of ways Congress could slow the growth in spending for GME. For example, it is not clear that the value to Medicare of the increasing num-

ber of residents is worth the cost. One approach would be to set a cap on total GME payments related to the number of residents in a base year. If the number of residents increases, then payments per resident would be reduced to keep the pool constant.

As I noted, there are large variations in per resident payments across teaching programs. Another option, therefore, is to set an upper limit on the amount of the payment per resident. The annual update in per resident payments could also be reduced for specialty residents or for all residencies. In addition, Medicare could restrict payment to only one period of residency training or to a certain number of years of training.

Targeting Payments to Disproportionate Share Hospitals

Hospitals that treat a disproportionate share of low income patients also receive an adjustment to their PPS payments. Many of these hospitals experience difficulties recruiting physicians and other staff, meeting the special needs of their patients, and obtaining sufficient revenue to cover the costs of caring for large numbers of individuals without insurance. The DSH adjustment is intended to help assure access to care for Medicare beneficiaries who rely on these hospitals. In contrast to the IME adjustment, the DSH adjustment does not reflect additional Medicare operating costs per discharge, except for large urban hospitals. In OBRA 1989 and OBRA 1990, Congress substantially increased the amount of DSH payments. In 1989, these payments were $1.1 billion. By 1994, they had increased to $3.4 billion (Chart 9).

Some hospitals, however, benefit from these extra payments without bearing the same burden in terms of financial losses as other hospitals. For example, disproportionate share hospitals in large urban areas have the lowest average total margin and the highest share of negative margins of any group of hospitals. In contrast, disproportionate share hospitals in other urban and rural areas have much higher than average total margins.

One approach the Congress can consider is scaling back the substantial expansions in DSH payments that were enacted in 1989 and 1990. It also would be desirable to better target the available funds to those hospitals with the largest share of low income patients that are essential to maintain access for Medicare beneficiaries. Recent ProPAC analyses, however, have not been able to identify a substantially better mechanism to target funds due to deficiencies in the current measures and data. A new set of measures and a new source of data will be necessary to better target available disproportionate share funds.

Targeting Payments to Sole Community Hospitals

Sole community hospitals (SCHs) are considered to be the main source of care for a geographically isolated population. SCHs are paid the higher of the applicable PPS payment or their hospital-specific costs in 1982 or 1987, updated to the current year. About 60 percent of SCHs currently receive payment based on their hospital-specific base year costs. In addition, other Medicare policies allow many of these hospitals to qualify for DSH payments under policies applicable to urban hospitals.

About 600 hospitals are designated as SCHs. The PPS margins for these hospitals have increased substantially as a result of recent changes in Medicare policies. The overall financial condition of these hospitals also is better than the average hospital (Chart 8).

Many of the hospitals that receive special treatment under the SCH provisions are not truly isolated, because they were "grandfathered" when the current designation criteria were implemented. The Congress may wish to limit the special treatment for SCHs to those that are truly isolated and serve as the only available hospital for Medicare beneficiaries residing in remote areas.

Correcting for Capital Cost Overestimates

The costs hospitals incur to acquire capital were excluded from PPS when it was implemented beginning in late 1983, with payments continuing on a reasonable cost basis. In fiscal year 1992, hospitals began a 10-year transition to a fully prospective payment system for capital. During the transition, each hospital's capital payment is based on one of two methods. The determination of the method as well as the amount of payment to each hospital is based in part on a comparison of each facility's "hospital-specific rate" (updated base year capital costs) and the adjusted "Federal rate" (a national average capital cost per discharge).

The projections for the expected growth in capital costs from the base year to 1992 were estimated using the best data available at the time. In fact, we now know that the updates applied to inflate the rates to 1992 were too high. Consequently, both the hospital-specific rate and the Federal rate are higher than they would have been if actual data had been available. In OBRA 1993, Congress partially corrected for

the overestimates by reducing the Federal capital rate. Both the hospital-specific rate and the Federal rate, however, continue to be higher than intended. Congress may wish to reduce the level of both rates to bring them in line with actual capital costs prior to the beginning of the transition.

In addition, beginning in FY 1996 the budget neutrality adjustment that has governed capital update policies expires. Consequently, capital payments per case are expected to rise more than 20 percent in 1996. This raises the issue of whether the base payments rates are appropriate. Congress also could adjust the capital payment rates to reduce or eliminate this substantial rise in payments.

EXCLUDED HOSPITALS

Certain specialty hospitals and distinct-part units of general hospitals are excluded from PPS, if they meet certain requirements. These facilities include psychiatric and rehabilitation hospitals and distinct-part units, as well as children's, long-term care, and cancer specialty hospitals.

Each excluded provider is paid on the basis of its current Medicare allowable inpatient operating costs or a target amount. The target amount is based on the provider's costs per discharge in a base year, updated to the current year by an annual update factor. This payment mechanism rewards providers that keep their costs below the target amount and penalizes those that exceed the amount.

From 1989 to 1993, a market basket measure of price increases was used to update the target amount for these facilities. In OBRA 1993, Congress reduced the update factor by up to one percent for certain facilities for fiscal years 1994 through 1997.

Excluded facilities account for a small share of total Medicare spending, although this share has been growing rapidly as more beneficiaries use these services. Congress could slow spending growth modestly by further reducing the annual update factor. The number of these facilities is growing rapidly, however, and the major factor driving Medicare spending growth is the continuing increase in the number of Medicare beneficiaries receiving services. To slow spending growth over the long term, major changes in Medicare's policies will be necessary. The research necessary to develop these new policies, however, is still incomplete.

HOSPITAL OUTPATIENT SERVICES

Mr. Chairman, I would like to turn now to Medicare reimbursement for hospital outpatient services. Because of its rapid growth, hospital outpatient spending is an increasing share of total Medicare expenditures. For the past several years, the Commission has recommended a correction to the formula that determines hospital outpatient payments for ambulatory surgery, radiology, and other diagnostic services that would generate significant savings.

Currently, hospitals are reimbursed for these services based on a formula that incorporates the hospital's costs and charges, and a prospective rate. Medicare program payments are then reduced to reflect beneficiary coinsurance. The problem, Mr. Chairman, is that the beneficiary's coinsurance is not based on Medicare's payment but on each hospital's charges. Hospital charges are about two times higher than Medicare payments, according to HCFA estimates. Thus, the beneficiary coinsurance is significantly more than the traditional 20 percent of payments. Because the Medicare payment formula does not fully offset these higher beneficiary copayments, hospitals end up receiving higher payments than Congress intended.

While correcting this formula-driven overpayment could generate significant savings, ProPAC recognizes that beneficiary payments that now represent 50 percent or more of total payments also is not what Congress intended. The Commission believes that these amounts could be reduced by linking the coinsurance payment to an estimate of payments, rather than charges. We are aware that correcting this flaw would increase Medicare outlays and, therefore, have recommended that the savings achieved by correcting the payment formula should be used to reduce the excessively high beneficiary copayments.

SKILLED NURSING FACILITY SERVICES

Mr. Chairman, I next would like to turn to Medicare's post-acute benefits—skilled nursing care and home health services. The Medicare skilled nursing facility (SNF) benefit is intended to be an extension of a hospital stay, at a lower level of care. As I mentioned previously, Medicare spending for SNF services is escalating rapidly. This growth is related to the rising number of beneficiaries using SNF services and increases in the number of days per person served (Chart 10). These increases are due in part to decreasing lengths of stay in the inpatient hospital setting. Spending growth also has increased recently due to substantial increases in average daily

SNF reimbursement (Chart 11). ProPAC has examined this recent growth. We believe it is related to a surge in the number of ancillary services being furnished and billed for separately from the routine per diem payment.

SNFs are paid their costs for routine per diem operating expenses, subject to a limit. A separate payment is made to cover capital costs. Free-standing skilled nursing facilities are paid the lower of their costs or 112 percent of the average per diem costs for urban or rural providers during a base year period. Hospital-based facilities receive a higher limit that is based on a combination of the free-standing limit and 112 percent of the average costs for all hospital-based facilities. These limits are periodically updated.

OBRA 1993 froze the SNF cost limits for fiscal years 1994 and 1995. Congress could continue to freeze or limit the increase in per diem cost limits for these facilities. An alternative is to reduce the cost limit level from the current 112 percent of the average to a lower amount. Another option to slow spending growth would be to reduce or eliminate the differential between hospital-based and free-standing limits. I need to note again, Mr. Chairman, that while these changes would slow the growth in per diem payments, they would have little impact on the increase in utilization that is primarily responsible for driving up spending.

In addition to these payments, skilled nursing facilities receive reasonable costs (without limits) for the ancillary services provided to patients receiving SNF-level care. They also may bill under Part B of Medicare for ancillary services furnished to inpatients who have exhausted Part A benefits or to outpatients. Our examination of the increasing ancillary usage in SNFs indicates that Medicare's current cost-based payment for these services may be providing inappropriate incentives to increase the use of these services. One solution is to switch from cost-based reimbursement to the Medicare resource-based relative value scale (RBRVS) to pay for these services. These rates are used when these services are furnished in other settings.

HOME HEALTH CARE

Home health services are the fastest growing spending category in the Medicare program. As I mentioned earlier, increases in the number of beneficiaries who use this benefit and the number of services they receive are responsible for almost all of this growth (Chart 12). The number of beneficiaries using this benefit has doubled over the past 10 years. In addition, the average number of services used by each of these individuals has increased by almost 25 percent in just the last two years.

To qualify for the home health benefit, beneficiaries must be confined to the home, be under the care of a physician who prescribes home care, and require either intermittent skilled nursing or physical therapy services. Prior to OBRA 1980, Medicare required beneficiaries to have been in the hospital for a minimum of three days prior to receiving the home health service. Medicare also limited the number of visits to 100 per year. Since then, there has not been a hospitalization requirement or a limit on the number of visits a beneficiary may receive. More recently, HCFA liberalized the requirements necessary to obtain home health services in response to a court order.

Medicare reimburses home health agencies their costs for the services they provide, subject to a limit. Each of the six types of services has a separate limit that is based on 112 percent of the mean cost per visit for all providers. An aggregate limit is then set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by that agency. Separate limits are set for rural and urban providers. The cost limits are updated annually using the home health market basket and adjusting labor costs by the current hospital wage index. As you can see, Mr. Chairman, this is an extremely cumbersome payment system and one that encourages these facilities to increase the number of visits they provide.

Over the past several years, Congress has attempted to rein in spending for home health care. The cost limits have been reduced from 120 percent to 112 percent of the mean cost per visit, the annual increases in the limits were frozen for fiscal years 1994 and 1995, and the administrative and general add-ons for hospital-based providers were eliminated.

While the Congress could reduce the cost limits per visit from 112 percent of the mean to a lower limit or continue to freeze or restrain the annual update, these actions will not address the fundamental factor driving spending growth, which is the increased utilization of services.

Similar to the Medicare SNF benefit, home health care was intended originally to be a post-acute benefit. Congress could change the current nature of the benefit

and return to the policies that were in place prior to the 1980 law. That is, it could place a limit on the number of visits that a beneficiary could receive. It could also tighten the rules regarding the use of this benefit. Alternatively, a more formal managed care system could be developed to accomplish this goal. In 1992, 6.3 percent of all Medicare beneficiaries used home health services. The average number of visits per person was 54, although half of the beneficiaries used less than 25. On the other hand, almost 18 percent of the users had more than 100 visits and 10.8 percent of the users had over 150 visits (Chart 13).

Congress also could return to the prior hospitalization requirement for beneficiaries to be eligible to receive home health services. Because the use of this benefit is growing so rapidly, it is difficult to get good data on the number of beneficiaries that have a hospitalization prior to using home health services. An analysis by ProPAC using 1990 data indicated that about 40 percent of users did not have a hospital stay within 30 days. A more recent analysis by HCFA indicated this proportion had decreased to about 35 percent.

Another option that has been considered is to institute a copayment. Unlike hospital, nursing facility, or physician services, the beneficiary does not have any responsibility to share in the rapidly growing costs of this benefit. If Congress were to consider this option, there would be other questions to address. These include determining the amount of the copayment and whether it would apply from the first visit or after a certain number of visits.

The average reimbursement per home health visit in 1994 is estimated to be about $63. A copayment of 10 percent for 100 visits would total $630. This amount is less than the deductible for an inpatient hospital stay in 1994. If Congress decides not to require a prior hospital stay, an alternative would be to require a copayment only for users who did not have a prior stay.

Finally, Mr. Chairman, I am aware of proposals that would move home health reimbursement from cost-based to a prospective payment system, with incentives for agencies to control the number of visits per enrollee. I generally favor such an approach, although there are important details to be worked out to accurately measure case mix and to eliminate incentives for agencies to increase the number of enrollees they serve.

MEDICARE MANAGED CARE

As I have described, much of the growth in Medicare spending is due to increases in service use inherent in Medicare's fee-for-service policies. While some of the growth can be slowed by tightening up on current policies, other approaches are necessary in the long-term. Increasingly, private sector payers are turning to managed care as a way of controlling their rising health care expenditures. Managed care plans rely on a limited number of providers and capitated payment rates to manage both the price and volume of services.

Medicare offers beneficiaries the option of enrolling in a risk-based managed care plan that is similar to private sector managed care. Overall enrollment in these plans has risen since the late 1980s, from 3 percent of the Medicare population in 1988 to 7.3 percent in June 1995. While these figures lag behind the enrollment rate in the general population, in several states, such as California and Arizona, about 30 percent of Medicare beneficiaries are enrolled in risk plans. At the other end of the spectrum, a number of states have virtually no Medicare managed care enrollment.

THE RISK CONTRACTING PROGRAM

The Medicare risk program has the potential to reduce the rise in Medicare spending. The evidence to date, however, indicates that it has not achieved this goal. There are a number of reasons for this. They include the methodology used to calculate the payment for each plan, requirements regarding differences between each plan's payments and expected costs, and Medicare's policies regarding enrollment and disenrollment, including the lack of an adequate adjustor for health status. There also are problems regarding Medicare's extra payments to teaching, disproportionate share, and rural hospitals that I will describe.

The development of Medicare's payment rate is based on a simple idea that has not worked as intended. The notion was to calculate a capitated amount that gives HMOs incentives to provide care at less cost than fee-for-service providers. In concept, Medicare was to generate savings because its payment to risk plans is set at a level less than the average spending that would otherwise be expected to occur in an area. Medicare pays a risk plan a capitated rate equal to 95 percent of the expected average Medicare fee-for service program spending in the county in which the enrollee lives. This average county-level spending is called the adjusted average

per capita cost or AAPCC. This amount is adjusted to reflect each beneficiary's age, sex, Medicaid status, institutional status, and employer-based coverage. In practice, this payment approach has numerous flaws that discourage many plans from participating and limit savings to the Medicare program.

Calculating the Amount of the AAPCC

A major problem with the AAPCC is the geographic area used to calculate the capitated payment rate. This area currently is the county. Many small counties, however, may not have a sufficiently large population to adequately average year to year fluctuations in fee-for-service payments. This may result in wide variations in the AAPCC from one year to another. Between 1994 and 1995, in the top 50 counties in terms of risk enrollment, the increase in the AAPCC ranged from 2.1 percent to 9.5 percent (Chart 14).

There also are large variations in payment rates among areas. In the top 50 counties, the monthly payment rates in 1995 varied from $292 in Marion County Oregon to $647 in Kings County New York. In addition, a plan offering services across several neighboring counties may receive very different capitated amounts even though their costs per beneficiary may be similar (Chart 15). For example, in 1995 in the Washington D.C. area the monthly capitated rate varied from $361 in Fairfax County to $543 in Prince Georges County. In the Minnesota Twin Cities Metro Area, the rate varied from $277 to $380.

The variability and uncertainty regarding the level of the AAPCC may discourage some plans from participating in the program. Currently, about 28 percent of plans operating in the private sector participate in Medicare's risk contracting program. The wide variation in payment rates at the county-level also provides incentives and opportunities for plans to attract beneficiaries who live in counties with higher payment rates and to avoid those in counties with low rates.

Part of the variation may be due to flaws in the calculation of the AAPCC, which excludes average expenditures for VA, military, or other programs used by Medicare enrollees. A recent ProPAC analysis found that the value of the services provided to Medicare beneficiaries by these non-Medicare programs averaged about 3.1 percent of total Medicare per enrollee costs across all states. The variation across individual states ranged from 1.2 percent to 7.4 percent. The failure to recognize the value of the services furnished to Medicare beneficiaries by VA and DoD facilities results in a capitated amount in some counties that is too low, possibly discouraging plan participation.

While fee-for-service spending may provide a useful benchmark to gauge the level of the capitated payment, setting the rate at this level may not obtain for Medicare the savings, especially in high cost areas, that HMOs should be able to achieve.

Comparing Expected Costs and Payments

Rather than sharing in the savings from HMO efficiencies, Medicare allows plans to choose to either return any difference between expected cost and Medicare payments to the program or to provide additional benefits, that otherwise would not be covered by Medicare, to the beneficiary. Not surprisingly, plans opt to provide the benefits rather than returning the savings.

These policies limit Medicare savings and result in beneficiaries' benefit packages varying by plan and the county in which they reside. ProPAC has recently completed an analysis of the effects of these policies. Plans that wish to enter into or continue risk contracts are required to submit an adjusted community (ACR) rate proposal that calculates their expected cost (which include overhead and profits) to provide Medicare covered services to Medicare enrollees. If these costs are less than the expected payment, plans are required to provide additional benefits to the enrollee or to return the difference to the Medicare program. Our analysis of the ACR data indicate that managed care plans in areas with high fee-for-service (FFS) costs have higher costs, as expected, than plans in areas with lower costs. However, the costs incurred by managed care plans rise more slowly than FFS costs and Medicare payments. In fact, our analysis showed that in 1994 a $100 increase in Medicare's monthly premium was associated with only a $72 increase in a plan's cost of providing Medicare covered services. Consequently, in high cost areas plans returned $28 in additional services or reduced liability to the beneficiary for every $100 increase in the AAPCC, and Medicare did not share in the savings.

There is substantial variation in the monthly value of the added benefits that are provided at no cost to Medicare risk plan enrollees (Chart 16). The top 10 percent of enrollees received additional monthly benefits worth between $111 and $139. At the other end of the spectrum, 10 percent of enrollees received additional benefits of less than $10 with some receiving no extra benefits.

Risk plans operating in markets with high HMO penetration may also be discouraged from Medicare participation if competition in their area, or other factors, results in lower FFS costs and hence a lower AAPCC. Our analysis indicates that markets with high HMO penetration have experienced somewhat lower rates of increase in FFS costs. However, the amount of the difference is small, especially when compared with the large variation in AAPCCs across counties.

There is one other aspect of Medicare's treatment of expected plan cost and payments that I would like to mention, Mr. Chairman. As part of their calculations, plans include the combined percentage of their costs due to administrative overhead and profits in their private business. Medicare allows them to keep this same percentage of their expected costs for overhead and profit. Since Medicare's capitated payment is much higher than the capitated rate in their private business, the actual payment per enrollee for administrative costs and profit is also much higher. This policy encourages plans with high administrative costs and profits to participate in the Medicare program, and it discourages plans that have kept these costs low.

Teaching, Disproportionate Share, and Rural Hospitals

There also are substantial problems with the way the Medicare risk contracting program deals with payments to teaching, disproportionate share, and vulnerable rural hospitals. Capitation and managed care in the public and private sectors is designed to increase the pressure on all providers to contain costs in order to compete. Certain providers, such as those located in remote rural areas or urban underserved areas, may be disadvantaged in responding to such pressure. Other providers that furnish services such as training of the future health care work force and research and those that serve a disproportionate share of low income patients are also at risk. During 1994, 41 million people had no health insurance at some time during the year. Hospitals, physicians, and other providers traditionally have furnished needed services to many of the uninsured, by subsidizing these costs.

In 1995, the Medicare program will provide about $10 billion in extra payments to certain rural, teaching, and disproportionate share hospitals to recognize the costs they incur that other hospitals do not bear. Because the AAPCC is based on Medicare's total fee-for-service payments in a particular geographic area, it includes the special payments to these facilities. Plans, however, are not obliged to use these providers or pass along the extra payments to them. Hence, hospitals with these extra costs may not be receiving Medicare's extra payments. Removing these extra payments from the calculation of the AAPCC and distributing them to the appropriate providers, based on the care they furnish to Medicare beneficiaries, would allow these facilities to compete for patients on a more equal footing with other providers in their area.

LACK OF ADJUSTMENT FOR HEALTH STATUS

Another concern with Medicare's capitation rate is the lack of an effective means to adjust payments to reflect differences in beneficiary health status. Medicare uses five factors to adjust the capitated rate—age, sex, institutional status, Medicaid status, and employer-based coverage. However, these measures still fail to take into account other factors that influence the need for care. Since enrolling sicker and more costly beneficiaries increases financial risk, plans have strong incentives to avoid these patients. The recent evaluation of the risk contracting program found that this lack of an adequate risk adjustor was responsible for the failure of the risk contracting program to achieve the Medicare program savings that were expected.

Adjusting capitated payment rates to reflect health status will be more important for the Medicare program than the private sector because Medicare enrollees generally are sicker than the general population. It is even more critical to do so, however, since it may be easier for plans to identify and avoid more costly Medicare beneficiaries.

IMPROVING MEDICARE'S MANAGED CARE PROGRAMS

Major changes in Medicare's policies are necessary to achieve the savings that are possible through managed care. Information presented to the Commission suggests that managed care is capable of generating significant reductions in beneficiary utilization without impairing access to quality care. In addition, ProPAC analyses have shown that those states with the lowest hospital per capita cost increases between 1980 and 1993 generally had the highest percentage of private sector HMO enrollment in 1993. In contrast, all the states with the highest per capita cost growth had lower than average HMO enrollment (Chart 17).

Medicare, however, is not taking advantage of the potential for savings. To do so requires altering the method for determining the monthly capitated rate and the

services included within this rate, changing the incentives for beneficiaries to choose this option, and encouraging HMO growth and participation in the program.

The first step is to change the way Medicare determines its capitated payment amount, especially breaking the link to fee-for-service spending at the county level. The county should be eliminated as the geographic area used to determine the capitated amount. There are a number of alternatives that can be considered, including Medicare's current geographic groupings (metropolitan statistical areas) used for hospital payment. The feasibility of combining counties to achieve a minimum population level or to reflect reasonable managed care market areas also should be explored. The capitated rate also should not include Medicare's graduate medical education, indirect medical education, or disproportionate share payments. Other mechanisms can be used to distribute these payments to the appropriate facilities when they provide services to Medicare beneficiaries enrolled in the managed care program.

The capitated rate that is set should cover Medicare's standard benefit package, although plans should be allowed to offer supplemental benefits to their enrollees for an additional premium. The current practice of comparing a plan's expected costs with its expected payments and allowing it to use the difference to provide additional benefits severely limits the opportunity for the Medicare program to share in the savings from more efficient service delivery. It also alters the uniform benefit structure of the Medicare program and raises questions of fairness for those beneficiaries who reside in relatively low cost areas.

Medicare's beneficiaries also should share in the savings when they choose a cost efficient plan. This can be done by linking their cost sharing requirements to the plan's premium. Beneficiaries that choose a more costly plan should share in the additional cost of their choice. Such an approach maintains Medicare's tradition of freedom of choice but provides financial incentives for beneficiaries to evaluate the value of a higher cost plan in terms of their added payment responsibilities. Plans, however, must make price, access, and quality of care information available to Medicare enrollees during a coordinated annual open enrollment period.

Newly enrolled beneficiaries also should be given a limited period of time following each enrollment period during which they can switch plans or return to the fee-for-service sector. Thereafter, however, they should be required to wait until the next enrollment season.

Current program rules require participating HMOs to enroll at least 50 percent of their membership from sources other than Medicare or Medicaid. When this requirement was established, it was intended to be a quality assurance measure. The rule was predicated on the assumption that quality care for Medicare beneficiaries could be enhanced since plans would have to provide an appropriate level of care to attract private sector enrollees. Since then, quality measures have been developed in the private sector that allow enrollees to compare plan prices, outcomes, beneficiary satisfaction ratings, and other related information. These measures are now being refined to reflect the elderly population. Medicare should adopt these more sophisticated alternatives for assuring quality of care, rather than relying on arbitrary enrollment percentages.

Finally, Mr. Chairman, the Medicare program needs to move quickly to improve its ability to adjust payment rates to reflect differences in the health status of Medicare beneficiaries. Coordinated annual enrollment and other plan requirements can help to reduce the ability of plans to select the healthiest enrollees. Healthier beneficiaries will be more likely to enroll in managed care plans, so the Medicare program will need to risk adjust its payments. Without risk adjusted payments, savings from Medicare's managed care program will be constrained.

In addition, the Medicare program needs to better manage the care furnished to all of its beneficiaries. One way to do so is to move quickly to develop the other types of managed care products that are available in the private insurance market. In 1993, 24 percent of insured individuals in the private sector were enrolled in HMOs, and an additional 40 percent of individuals were enrolled in preferred provider organizations (PPOs). PPOs use fee-for- service payment methods, with some limits on the choice of providers. They also manage some of the care that is furnished. Many of them also offer their enrollees the choice of paying an additional amount to see a provider that is not part of their PPO.

CONCLUSIONS

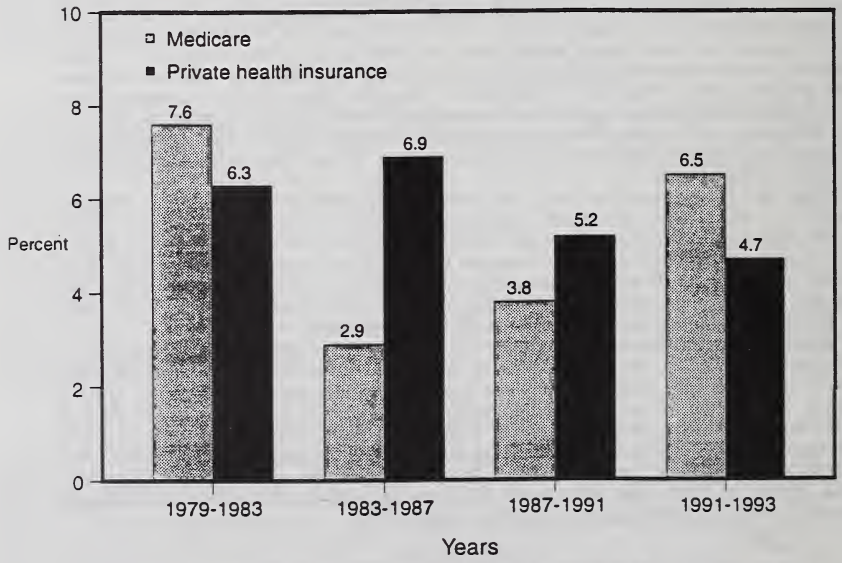
Mr. Chairman, today I have suggested a number of areas that the Congress could consider for reducing Medicare spending growth in the short term. These approaches generally parallel past practices of modifying the payment level for specific services furnished by specific providers. I must caution, however, that there are lim-

its to this approach beyond which cuts could seriously hinder the ability of these providers to offer quality services Over time, new strategies are necessary to control increases in the Medicare program's spending and particularly increases in the volume of services that are used by beneficiaries. Managed care strategies have the potential to do this. As I have indicated, however, changes are needed in Medicare's risk contracting program to encourage beneficiary and plan participation and to achieve the savings that are possible. In addition, new types of managed care products need to be developed. The challenge is to make the short-term adjustments that are necessary to slow the rise in spending while you also move toward longer-term reforms of the Medicare program.

The Commission would be pleased to work with you and your staff as you struggle with both short and long-term options for controlling the growth in Medicare spending. This completes my testimony, Mr. Chairman. I would be pleased to answer any questions you and the members of the Committee have.

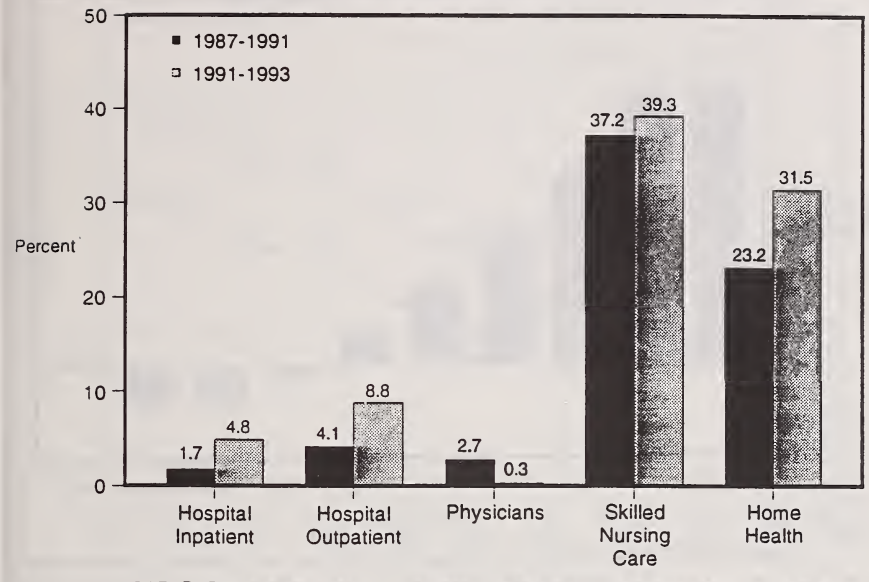
Prospective Payment Assessment Commission

Chart 1. Real Annual Change in Medicare Expenditures Per Enrollee and Private Health Insurance Per Member, 1979-1993 (In Percent)



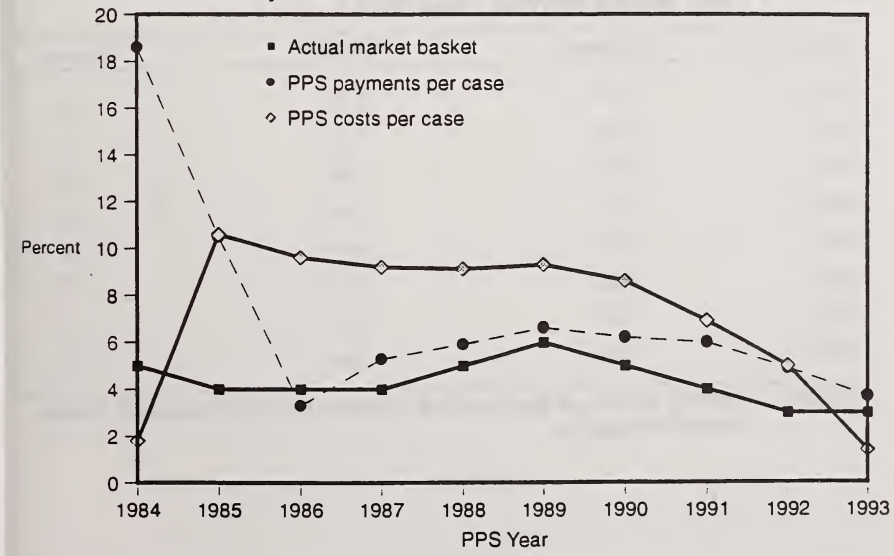
SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

Chart 2. Real Average Annual Growth Rates Per Enrollee for Selected Medicare Services, 1987-1993 (In Percent)



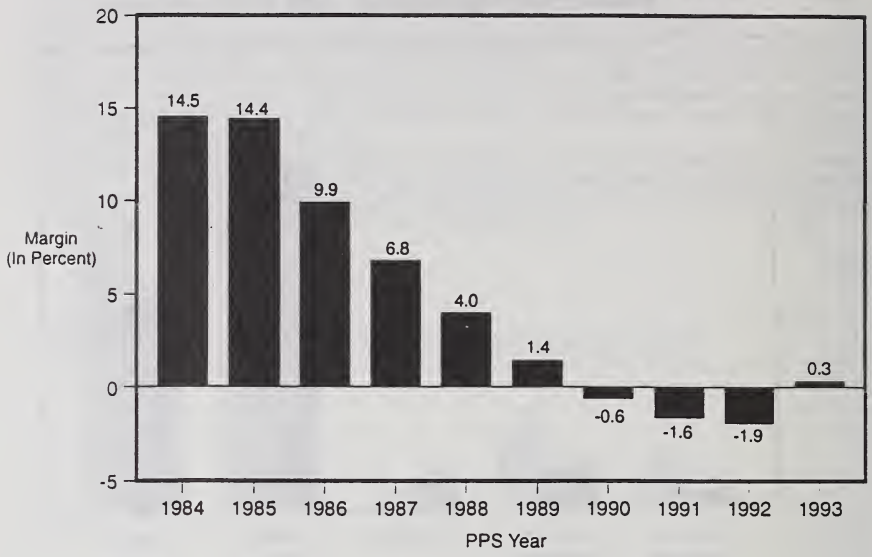
SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

Chart 3. Annual Increase in Actual Market Basket and PPS Payments and Costs Per Case, First Ten Years of PPS



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 4. PPS Margins for All Hospitals, First Ten Years of PPS



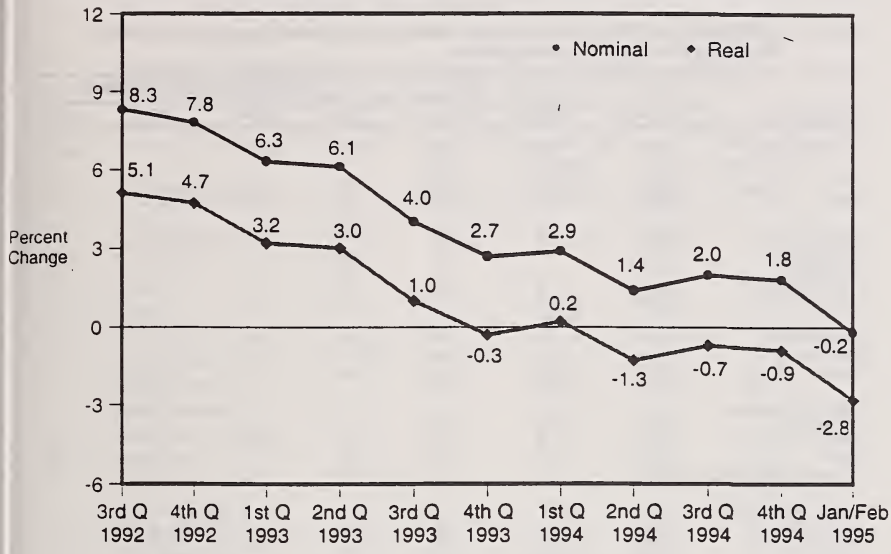
SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 5. Hospital Payment to Cost Ratios for Medicare, Medicaid, and Private Payers, 1980-1993

Year	Medicare	Medicaid	Private
1980	0.96	0.91	1.12
1982	0.96	0.91	1.14
1984	0.98	0.88	1.16
1986	1.01	0.88	1.16
1988	0.94	0.80	1.22
1990	0.89	0.80	1.27
1992	0.89	0.91	1.31
1993	0.89	0.93	1.29

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

Chart 6. Quarterly Change in Hospital Cost Per Adjusted Admission



Note: Each period is compared to the same period the previous year.

SOURCE: American Hospital Association Hospital Panel Survey.

Chart 7. Distribution of PPS Hospitals and Discharges and Estimated Fiscal Year 1995 PPS Operating Payments, by Hospital Group

Hospital Group	Number of PPS Hospitals	Percent of Discharges	Percent of Payments	PPS Operating Payments (In Billions)			
				Total	Outlier	IME	DSH
All hospitals	5,199	100%	100%	$66.5	$2.9	$3.9	$3.8
Urban	2,906	80	87	57.9	2.7	3.9	3.6
Rural	2,293	20	13	8.6	0.2	*	0.2
Large urban	1,599	46	54	35.7	1.7	2.9	2.4
Other urban	1,307	34	33	22.2	1.0	0.9	1.3
Rural referral	210	6	4	3.0	0.1	*	0.1
Sole community	616	4	2	1.6	*	*	*
Other rural	1,467	10	6	4.1	0.1	*	0.1
Major teaching	239	11	18	12.1	0.6	2.6	1.3
Other teaching	806	32	34	22.8	1.1	1.4	1.2
Non-teaching	4,154	58	48	31.6	1.2	0.0	1.3
Disproportionate share:							
Large urban	765	23	30	20.3	0.9	2.2	2.4
Other urban	660	20	21	13.8	0.6	0.8	1.3
Rural	503	6	4	2.7	0.1	*	0.2
Non-disproportionate share	3,271	51	45	29.7	1.3	1.0	0.0
Payment adjustments:							
IME and DSH	652	26	35	23.1	1.1	3.0	2.5
IME only	393	16	18	11.8	0.6	1.0	0.0
DSH only	1,276	23	21	13.7	0.5	0.0	1.3
No IME or DSH	2,878	35	27	18.0	0.7	0.0	0.0
Urban <100 beds	725	5	3	2.2	0.1	*	*
Urban 100-199 beds	904	16	15	10.0	0.4	0.2	0.7
Urban 200-299 beds	599	21	21	13.9	0.6	0.5	0.7
Urban 300-399 beds	315	14	16	10.6	0.5	0.6	0.7
Urban 400-499 beds	174	10	12	7.9	0.4	0.8	0.5
Urban 500+ beds	189	14	20	13.3	0.7	1.8	1.0
Rural <50 beds	1,186	4	2	1.4	*	*	*
Rural 50-99 beds	684	6	4	2.5	*	*	*
Rural 100-149 beds	228	4	3	1.7	*	*	*
Rural 150-199 beds	102	3	2	1.2	*	*	*
Rural 200+ beds	93	3	3	1.9	0.1	*	0.1
New England	223	6	6	4.2	0.2	0.4	0.1
Middle Atlantic	526	17	20	13.4	0.9	1.3	0.9
South Atlantic	734	17	16	10.9	0.5	0.4	0.7
East North Central	801	18	17	11.4	0.4	0.8	0.4
East South Central	453	8	7	4.4	0.2	0.1	0.3
West North Central	735	8	7	4.7	0.1	0.3	0.1
West South Central	745	10	9	6.1	0.3	0.2	0.4
Mountain	345	4	4	2.7	0.1	0.1	0.1
Pacific	637	11	13	8.6	0.3	0.3	0.7
Voluntary	3,230	76	78	51.7	2.3	3.2	2.6
Proprietary	720	11	10	6.9	0.3	0.1	0.4
Urban government	360	7	9	5.8	0.2	0.6	0.7
Rural government	851	5	3	2.1	*	*	0.1

Note: PPS payments estimated using rules in effect as of October 1, 1994. Numbers may not sum due to rounding. Excludes hospitals in Maryland. IME = indirect medical education. DSH = disproportionate share.

* Less than $0.05 billion.

SOURCE: Estimates based on ProPAC PPS payment model, Congressional Budget Office March 1995 estimates, and fiscal year 1993 MedPAR file data from the Health Care Financing Administration.

Chart 8. PPS and Total Margins, by Hospital Group, Tenth Year of PPS (In Percent)

Hospital Group	PPS Margin	Percent w/ Negative Margin	Total Margin	Percent w/ Negative Margin
All hospitals	0.3%	54.1%	4.3%	23.8%
Urban	0.6	54.4	4.2	23.0
Rural	-1.8	53.8	5.0	24.7
Large urban	1.9	50.3	3.5	25.5
Other urban	-1.5	59.3	5.3	20.1
Rural referral	0.2	49.5	6.0	8.7
Sole community	0.6	47.5	5.3	25.9
Other rural	-4.0	57.1	4.2	26.5
Major teaching	11.7	17.8	2.7	23.2
Other teaching	0.5	48.2	4.6	19.9
Non-teaching	-4.0	57.2	4.8	24.6
Disproportionate share:				
Large urban	7.9	33.6	3.0	27.9
Other urban	1.2	50.2	5.3	16.3
Rural	-0.2	47.0	5.7	23.6
Non-disproportionate share	-5.1	60.4	4.7	24.4
IME and DSH	7.7	30.8	3.5	22.3
IME only	-2.7	59.1	4.8	17.9
DSH only	-0.5	49.2	5.0	22.9
No IME, No DSH	-6.6	60.6	4.6	25.3
Voluntary	0.1	55.1	4.1	22.2
Proprietary	1.8	47.8	6.4	29.0
Urban government	3.0	52.2	4.3	20.9
Rural government	-4.8	55.5	4.4	27.5

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 9. Medicare Indirect Medical Education (IME) and Disproportionate Share (DSH) Payments, 1989-1994 (In Billions)

Fiscal Year	IME Payments		DSH Payments	
	Amount (In Billions)	Percent of Total PPS Payments	Amount (In Billions)	Percent of Total PPS Payments
1989	$2.2	4.8%	$1.1	2.4%
1990	2.5	5.3	1.6	3.3
1991	2.9	5.5	2.2	4.1
1992	3.1	5.7	2.2	4.0
1993	3.7	5.6	2.7	4.1
1994	3.8	5.7	3.4	5.1

SOURCE: Prospective Payment Assessment Commission, *Medicare and the American Health Care System Report to the Congress*, June 1989, 1990, 1991, 1992, 1993, and 1994.

Chart 10. Medicare Skilled Nursing Facility Utilization, 1980-1994

Year	Persons Served		Days	
	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1980	257	9	8,645	33.6
1981	251	9	8,518	33.9
1982	252	9	8,814	35.0
1983	265	9	9,314	35.1
1984	299	10	9,640	32.2
1985	314	10	8,927	28.4
1986	304	10	8,160	26.8
1987	293	9	7,445	25.4
1988	384	12	10,667	27.8
1989	636	19	27,780	43.7
1990	638	19	25,200	39.5
1991	671	20	23,700	35.3
1992	785	22	28,960	36.9
1993	870	24	34,437	39.6
1994*	925	25	36,865	39.9

* Estimated

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 11. Skilled Nursing Facility Reimbursement Per Day

Year	Reimbursement	Annual Rate of Increase
1980	$47.5	–
1982	55.8	8.4%
1984	58.2	2.1
1986	70.9	10.4
1988	86.7	10.6
1990	98.4	6.5
1992	148.1	22.7
1994*	207.3	18.3

* Projected

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 12. Medicare Home Health Care Utilization, 1980-1994

	Persons Served		Visits	
Year	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1980	726	26	16,322	22.5
1981	948	34	22,688	23.9
1982	1,154	40	30,628	26.5
1983	1,318	45	36,898	28.0
1984	1,498	50	40,422	27.0
1985	1,549	51	39,449	25.5
1986	1,571	51	38,000	24.2
1987	1,544	49	35,591	23.1
1988	1,582	49	37,132	23.5
1989	1,685	51	46,199	27.4
1990	1,940	58	69,565	35.9
1991	2,223	65	100,044	45.0
1992	2,523	72	134,844	53.4
1993	2,900	81	173,953	60.0
1994*	3,220	88	209,149	65.0

* Estimated

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 13. Distribution of Visits Across All Home Health Users, 1992 (In Percent)

Number of Visits	Percent of Users
1-20	45.2%
21-40	19.2
41-60	8.9
61-80	4.6
81-100	4.4
101-125	4.1
126-150	2.8
151-175	2.2
176-200	2.3
Over 200	6.3

SOURCE: Health Care Financing Administration, Office of Research and Development.

Chart 14. Comparison of 1994 Versus 1995 Aged Monthly Adjusted Average Per Capita Costs, by County Risk Contracting Enrollment

Rank*	County	State	1995 Total Rate	Total Rate Change from 1994	Total Percentage Change from 1994
1	Los Angeles	California	$558.76	$26.73	5.02%
2	San Diego	California	458.81	23.84	5.48
3	Broward	Florida	544.02	26.81	5.18
4	Dade	Florida	615.57	40.05	6.96
5	Orange	California	523.12	24.11	4.83
6	Riverside	California	464.00	18.58	4.17
7	San Bernardino	California	466.92	21.75	4.89
8	Maricopa	Arizona	440.64	22.53	5.39
9	Cook	Illinois	485.26	24.09	5.22
10	Palm Beach	Florida	473.41	21.38	4.73
11	Multnomah	Oregon	373.35	15.78	4.41
12	King	Washington	377.09	13.23	3.64
13	Hennepin	Minnesota	362.85	10.75	3.05
14	Pinellas	Florida	410.08	26.17	6.82
15	Volusia	Florida	364.96	20.90	6.07
16	Bexar	Texas	404.37	22.51	5.89
17	Monroe	New York	400.40	23.97	6.37
18	Pima	Arizona	399.81	14.14	3.67
19	Hillsborough	Florida	414.04	20.73	5.27
20	Ramsey	Minnesota	379.82	21.34	5.95
21	Worcester	Massachusetts	453.09	15.27	3.49
22	Pasco	Florida	438.80	27.27	6.63
23	Kings	New York	646.88	36.33	5.95
24	Clark	Nevada	462.83	33.01	7.68
25	Orange	Florida	433.50	21.69	5.27
26	Washington	Oregon	374.82	21.16	5.98
27	Clackamas	Oregon	350.45	23.26	7.11
28	Bernalillo	New Mexico	352.38	9.77	2.85
29	San Mateo	California	397.73	18.03	4.75
30	Ventura	California	445.67	23.33	5.52
31	Denver	Colorado	435.63	23.63	5.74
32	San Francisco	California	467.03	20.90	4.68
33	Queens	New York	592.89	32.74	5.84
34	Cuyahoga	Ohio	474.45	9.66	2.08
35	Middlesex	Massachusetts	480.33	16.84	3.63
36	Snohomish	Washington	364.28	14.08	4.02
37	Honolulu	Hawaii	352.89	14.30	4.22
38	Kern	California	444.28	29.58	7.13
39	Nassau	New York	514.93	30.12	6.21
40	Jackson	Missouri	435.32	17.33	4.15
41	Jefferson	Colorado	371.29	19.51	5.55
42	Clark	Washington	324.53	22.14	7.32
43	Philadelphia	Pennsylvania	625.81	17.48	2.87
44	Montgomery	Pennsylvania	465.04	17.57	3.93
45	Suffolk	New York	477.83	21.56	4.73
46	Marion	Indiana	418.97	18.02	4.49
47	Nueces	Texas	415.09	21.42	5.44
48	Erie	New York	360.33	9.58	2.73
49	Marion	Oregon	291.50	20.08	7.40
50	Anoka	Minnesota	342.40	29.69	9.49

* The county with the largest number of Medicare beneficiaries enrolled in risk contracting plans is given the number 1 ranking.

SOURCE: Health Care Financing Administration, Office of Managed Care.

Chart 15. Standardized Per Capita Rates of Payment for Aged Enrollees in Selected Areas, 1995

Area	Rate of Payment
Washington, DC-Maryland-Virginia	
Washington, DC	540
Prince Georges County, MD	543
Montgomery County, MD	426
Manassas Park City, VA	464
Falls Church City, VA	408
Alexandria City, VA	407
Arlington County, VA	396
Fairfax City, VA	367
Fairfax County, VA	361
Twin Cities metro area	
Ramsey (St. Paul)	$380
Hennepin (Minneapolis)	363
Anoka	342
Dakota	334
Washington	324
Carver	285
Scott	277
Southern Florida	
Dade	616
Broward	544
Palm Beach	473
Southern California	
Los Angeles	559
Orange	523
San Diego	459

Note: The 1995 U.S. per capita cost for aged enrollees is $401; 95 percent of the U.S. per capita cost is $380, which corresponds to the standardized per capita rate of payment.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 16. Monthly Value of Medicare Non-Covered Benefits Provided at No Cost to Medicare Risk Plan Enrollees, By Decile of Risk Plan Enrollees, 1994

Enrollee Decile	Monthly Value of Benefits
1	$ 0 - 10
2	10 - 27
3	27 - 39
4	40 - 45
5	47 - 52
6	55 - 63
7	64 - 75
8	75 - 89
9	91 - 110
10	111 - 139

* Each decile includes 226,800 risk plan enrollees.

SOURCE: ProPAC analysis of Adjusted Community Rate Proposal data from the Health Care Financing Administration.

Chart 17. Hospital Per Capita Cost Growth and Private Sector HMO Enrollment for Selected States (In Percent)

Rank	State	Hospital Per Capita Cost Growth 1980-1993[a]	1993 Private Sector HMO Enrollment[b]
1	Nevada	6.0%	16.7%
2	California	6.8	51.4
3	Kansas	7.4	8.5
4	Illinois	7.4	21.2
5	Arizona	7.4	29.6
6	Minnesota	7.5	31.8
7	Colorado	7.5	30.6
8	Maryland	7.7	37.2
9	Wisconsin	7.7	28.3
10	Rhode Island	7.8	36.6
National average	All	8.8	23.8
41	Georgia	9.7	10.8
42	South Dakota	9.9	5.1
43	New Jersey	9.9	21.0
44	North Carolina	10.0	10.5
45	Louisiana	10.0	13.9
46	Tennessee	10.1	7.2
47	Kentucky	10.3	17.8
48	Arkansas	10.3	7.0
49	South Carolina	10.5	5.6
50	New Hampshire	10.9	17.8

Note: HMO = health maintenance organization.

[a] Hospital per capita cost growth is measured as annual change in hospital costs per capita from 1980 to 1993.

[b] Private sector HMO enrollment is based on 1993 plan-level data as a proportion of each state's nonelderly privately insured population.

SOURCE: ProPAC analysis of data provided by InterStudy; Employee Benefit Research Institute; American Hospital Association; and Department of Commerce, Bureau of the Census.

Chart 18. State Rankings for Medicare Standardized Resource Costs Per Aged Enrollee and Health Status

State	Standardized Resource Costs Per Enrollee[a]	Health Status[b]
Oregon	1	4
Hawaii	2	5
Utah	3	1
New Hampshire	4	15
Minnesota	5	3
Idaho	6	9
New Mexico	7	26
Rhode Island	8	24
Washington	9	2
Maine	10	23
Kentucky	41	45
Pennsylvania	42	30
Texas	43	25
Maryland	44	35
Georgia	45	41
Tennessee	46	44
Florida	47	29
Mississippi	48	50
Alabama	49	49
Louisiana	50	46

Note: The state with the lowest cost and best health status is ranked number 1.

[a] Real resource costs are defined in Table 5-1, *Medicare and the American Health Care System Report to the Congress* (Washington, DC: Prospective Payment Assessment Commission, June 1995).

[b] Health status is measured as a composite of three age-adjusted mortality rates (infant deaths in 1992, cervical cancer deaths from 1986 to 1990, and colorectal cancer deaths from 1986 to 1990) and the low birthweight rate in 1991.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary, Bureau of Data Management and Strategy, and Office of Managed Care; the Departments of Defense and Veterans Affairs; and Lewin-VHI, Inc., *Health Care Problems: Variation Across States* (Washington, DC: National Institute for Health Care Management, 1994).

PREPARED STATEMENT OF PHILLIP I. HOFFMAN, M.B.A.

Mr. Chairman, my name is Phillip I. Hoffman. I am the Chief Financial Officer of Outreach Health Services, which provides Medicare covered home health services throughout the State of Texas through both for-profit and nonprofit organizations. I am testifying on behalf of my company and the Home Health Services and Staffing Association, whose diverse membership includes both large and small home care providers which operate over 1,500 offices in virtually every state and employ nearly 1/2 million caregivers.

My work experience includes participation in both Phase I and Phase II of the Prospective Payment Demonstration projects funded by the Health Care Financing Administration. I have also participated in the PPS Work Group, which consists of representatives from a broad cross-section of the home health industry (for-profit, nonprofit, hospital-based, and free-standing) that has been working over the past year to develop a prospective payment system. The Work Group has developed the prospective payment proposal I will describe today as a substitute for the current cost reimbursement system and as an alternative to copayments.

According to the General Accounting Office, Medicare expenditures for home health services in 1994 were $12 billion, which was 12% lower than had been projected in February of 1994.[1] By comparison, Medicare expenditures for all Part A services grew to $102.8 billion, which was 1.5% higher than had been projected. Thus, the growth rate in home health expenditures, which had been expected to decline, actually declined much more rapidly than had been predicted. Home health expenditures currently constitute approximately 11.5% of all Part A spending and just 7% of all Medicare spending.

Increasing concern has been expressed by ProPAC and others, however, over the rate of increase in Medicare expenditures for home health services, which has approached 25% over the past two years.[2] While much of that growth can be attributed to the trend of providing health care outside of the institutional setting, there is growing concern that some of that growth maybe caused by the current cost reimbursement system, which provides an incentive to furnish unnecessary visits, incur unnecessary costs, and provide services to patients for as long as possible. The Office of the Inspector General has found that the current system even encourages unscrupulous providers to pad their cost reports with personal and other unallowable costs and to file claims for visits that were not made.[3] Providers that seek to furnish services in a more cost effective manner simply receive less reimbursement under the current system.

Overlaying copayments on the existing system does nothing to curb the inefficiency and abuse caused by that system. Copayments simply shift a portion of the cost of that inefficient system to the patient in the form of a "sick tax" and erect a barrier to those who need care, especially the elderly and those with low incomes. Imposing copayments also creates an incentive for patients to remain in the higher cost hospital setting, because there is no copayment on the first 60 days of hospital care covered by Medicare.

It must also be conceded that copayments are a cut in the Medicare benefit rather than simply a reduction in the future rate of growth. Copayments also further burden the Medicaid program because certain beneficiaries are eligible to have their copayments and deductibles covered by Medicaid. Perhaps worst of all, copayments exacerbate the waste and inefficiency of the current reimbursement system by increasing administrative costs for providers and the government, while not improving the administration of benefit. In addition, bad debts which result when providers cannot collect copayments are charged to the Medicare program as an allowable cost.

There is a broad-based consensus in the home health industry that high quality services can be provided in a more cost effective manner if a prospective payment system could be established that provides incentives for controlling costs and disincentives for waste and inefficiency. The Work Group has developed such a proposal, which we believe could be implemented within 1 to 1-1/2 years because it uses current payment procedures combined with the prospective payment methodology which has been approved by HCFA for the Phase II Demonstration Project. A de-

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[1] "Medicare: High Spending Growth Calls for Aggressive Action," GAO/HEHS-T-95-75, 15-16 (February 6, 1995).

[2] See testimony of the Prospective Payment Assessment Commission. Hearing before Committee on Ways and Means Subcommittee on Health, Trans. at 15-16 (February 6, 1995).

[3] See Statement by the Office of the Inspector General, Department of Health and Human Services before Committee of Ways and Means Subcommittee on Health, Trans. at 3-4 (February 6, 1995).

tailed description of the plan is attached, but the most significant features are as follows:

1. A cap would be established on the aggregate payments any home health agency could receive from Medicare in any fiscal year based upon the episodes of care rendered by the agency. (An episode would be defined as 120 days after admission, as in the Phase II Demonstration Project funded by HCFA.)

2. Providers would be allowed to share in up to 40% of the savings achieved by keeping their payments for the year below the aggregate per episode cap. (Providers, therefore, would have an incentive to provide necessary services for less than the cap rather than an incentive to increase their costs up to a limit as under the current system. The trust funds would receive at least 60% of the incentive based savings.)

3. In order to maintain cash flow, home health agencies would be reimbursed for visits made during the year at a prospectively set rate based on the average cost of the service in the region.

4. The per visit rates and the per episode caps would be established for a base period and updated annually at a rate that is less than the projected growth in expenditures.

Simply stated, the proposal provides for per visit reimbursement subject to an annual aggregate cap.

This proposal has been scored by the accounting firm of Price Waterhouse as achieving savings of between $19 billion and $29 billion over 7 years, a savings which Price Waterhouse believes to be conservative. Savings may well be even greater, if home health providers respond to the incentives of this plan, as we believe they will. More importantly, these are true savings to the overall health delivery system rather than a cost shift to the patient or to insurers and other third party payors.

We believe this proposal has the following advantages:

1. It provides an effective mechanism for the government to control the growth rate in Medicare home health expenditures while preserving latitude for clinical decisions to be made by the physician, the patient, and the provider.

2. It creates incentives for home health providers to become more cost effective and innovative and rewards those that do.

3. It achieves true savings to the overall health system rather than shifting costs to the patient or other programs.

4. It avoids adding needless administrative costs, thereby helping to preserve home health services as a low-cost treatment option.

5. It significantly reduces the incentives for waste and abuse.

6. It can be implemented in the near future using available data and existing procedures and can be refined and ultimately converted to a "pure" per episode prospective payment system based upon data generated over the next three years by the Phase II Demonstration Project.

7. By avoiding a "sick tax" imposed on patients through copayments and providing incentives for providers to furnish cost effective services, this proposal will have strong support in the consumer and provider communities.

We do not contend that the Work Group proposal is the perfect prospective payment system or the system that might ultimately evolve. In fact, the Work Group is working with others in the industry to make improvements, and the plan is designed to be refined as experience is gained and data is generated over the next three years by the Phase II Demonstration Project. We believe, however, that the proposal is far superior to the current system or to the current system with copayments.

This Committee expressed its intent in OBRA '87 and '90 that home health reimbursement be switched to prospective payment.[4] That intent has not been fulfilled reportedly because no prospective payment system was "ready" for implementation. After nine years, it is clear that we will never have a prospective payment system "ready" for implementation without explicit direction from Congress. The Work Group has developed a system that has broad industry support. It saves money, improves efficiency, and avoids penalizing the patients or cutting the benefit. Rather than adhering to an antiquated, inefficient system or making it worse with copayments, we believe it is time we got on with implementing a prospective payment plan.

I appreciate the opportunity to present this proposal and would be glad to answer any questions.

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[4] See §4207(c) of the Omnibus Reconciliation Act of 1987 (Public Law 100-203) and §4207(c) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).

Enclosure.

PROSPECTIVE PAYMENT SYSTEM: A MORE EFFECTIVE ALTERNATIVE TO COPAYMENTS FOR CONTROLLING THE GROWTH IN HOME HEALTH EXPENDITURES UNDER PART A OF THE MEDICARE PROGRAM

Beginning approximately nine months ago, representatives of national and state home health service providers began meeting as the "PPS Home Health Work Group" to study whether a prospective payment system could be developed, based upon currently available data, that would more effectively control the rate of growth in home health expenditures under the Medicare program than would the imposition of a copayment. The Work Group included providers of all auspices—nonprofit, tax-exempt, proprietary, hospital-based, and free-standing.

The Work Group has developed a prospective payment system for home health services which could be implemented in 1996 using existing payment procedures, would achieve significant savings both near and long term, and would provide a rational transition to a pure per episode prospective payment system in the future once more reliable date is available from the per episode demonstration project currently being conducted by the Health Care Financing Administration. The Work Group believes that this proposal serves the interests of the government, the providers, and the beneficiaries far better than would the imposition of copayments.

Copayments are bad public policy because they:

(a) increase administrative costs of an already inefficient reimbursement system while not improving the services;

(b) shift costs to the Medicaid program, private insurers, or the patient rather than effect true savings;

(c) deprive the elderly and disabled poor of access to health care services that have been determined by their physician to be medically necessary;

(d) penalize the most cost effective providers the most severely; and

(e) create an incentive for physicians to keep patients in the hospital because there is no Medicare copayment for the first 60 days of inpatient hospital care (42 U.S.C. §1395e(a)(1)).

The Prospective Payment System developed by the Work Group is far better public policy because it:

(a) provides an effective mechanism by which the government can control the growth rate in home health expenditures while preserving latitude for clinical decisions to be made by the patient, the physician, and the provider;

(b) avoids adding needless administrative costs, thereby helping to preserve home health care as a low cost treatment option;

(b) achieves true savings by reducing the growth rate in expenditures while not shifting costs to patients or other programs;

(c) creates incentives for home health providers to become more cost effective and innovative and rewards those who do; and

(d) can be implemented in the near future using available data and can be refined and ultimately converted to a pure per episode prospective payment system as data is generated over the three year term of the Phase II prospective payment demonstration project.

This prospective payment system has been scored by Mr. Jack Rodgers of the accounting firm of Price Waterhouse as saving at least $19 billion over 7 years.

For more information, contact Jim Pyles at 202-466-6550.

PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES COVERED UNDER PART A OF MEDICARE

PRESENT LAW

Home health agencies that are certified for participation in the Medicare program are entitled to receive reimbursement for the costs actually incurred in providing services to Medicare beneficiaries that are covered under Part A of the Medicare program. Certified home health agencies may receive cost reimbursement up to a limit of the costs estimated to be necessary for the efficient delivery of needed health services. The limit is currently set at 112% of the mean of the labor and nonlabor per visit costs for freestanding agencies.

Section 13564(a) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66) provided that no changes would be made in the home health per visit cost limits for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996. In addition, § 13564(b) of OBRA '93 provided that, effective for cost reporting periods beginning on or after October 1, 1993, hospital-based home health agen-

cies would no longer receive an adjustment to their cost limits for administrative and general costs as they had since 1980.

In § 4207(c) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the Secretary of Health and Human Services was directed to develop and test alternative prospective payment methods for home health services and deliver a final report to Congress no later than December 1991.

In § 4207(c) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), the Secretary was directed to develop a modified or prospective payment reimbursement system for home health services and submit the proposal to the Senate Finance Committee and to the House Ways and Means Committee by not later than September 1, 1993.

The Secretary has initiated two demonstration projects to test prospective payment systems for home health services. The first project (Phase I) tested a prospectively set per visit methodology and was completed in September of 1994. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits. The second project (Phase II) will test a per episode prospective reimbursement methodology and is scheduled to commence on July 1, 1995 and run for a period of three years.

PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES

Summary

Home health services will be paid on a per visit basis subject to a per episode aggregate cap. The per visit payment rate will be established at a reduced percentage of the cost limits. The per episode cap will be based on the regional average cost for an episode of care as defined in the Phase II demonstration project. Both payment amounts will be established using base period costs which will be adjusted annually to account for changes in the home health market basket index.

Per Visit Payment

The Secretary will establish a per visit rate of reimbursement by discipline for Medicare certified home health agencies in each Metropolitan Statistical Area and Non-Metropolitan Statistical Area as prescribed in the home health cost limit rules. The per visit rate of reimbursement will be set at 105% of the mean labor and nonlabor costs for all home health agencies within a region.

Per Episode Cap

For the purposes of computing the per episode cap, an episode of care will be defined, as in the Phase II demonstration project, to include all covered services delivered during a period of 120 days following the initial admission of a beneficiary. A separate cap amount will be calculated by the Secretary for each of the 18 case categories used in the Phase II case mix adjustment methodology.

A single case mix adjusted aggregate per episode cap will be determined for each home health agency annually by multiplying the episodes in each case category times the per episode cap for that category and summing the products.

As soon as sufficient data is available, the Secretary will make a determination (subject to notice and an opportunity for public comment) with respect to whether the regional variations in the per episodes caps should be eliminated.

Savings Sharing

Home health agencies that are able to keep their total payments for the year below their annual aggregate per episode cap will share in the savings at a graduated rate which will increase with the percentage by which total payments are less than the cap.

The potential shared savings will range from 5% to 40% and will increase as the percentage by which the home health agency's total payments are below the cap increases, up to 20%. A provider whose total payments for a year were 1% under the annual aggregate per episode cap would be entitled to approximately 5% of the savings, while a provider whose total payments were 20% under the cap would be entitled to 40% of the savings. The percentage of savings share would not increase if a provider's total payments were more than 20% under the per episode cap.

Home health agencies would not be entitled to payments which exceed the annual aggregate per episode cap.

Home health agencies would be permitted to seek such exceptions and exemptions to the annual aggregate per episode cap as are currently available under the cost limit rules (e.g., sole community provider and extraordinary circumstances). The intermediaries will be required to make a determination on any such request within 120 days after the provider certifies that it has provided all information it feels is relevant.

Outliers and Extended Care Cases

Home health agencies which provide services to patients for longer than 120 days would be paid at their Usual per visit rate, but those payments would count against the annual aggregate per episode cap.

The Secretary would designate certain disorders or combinations of disorders which require a steady and predictable range of services over an extended period of time (e.g., blind diabetics) where a home health agency's opportunity to provide the services in a more cost-effective way is limited. For such cases that are certified in the first 120 days of service, the provider would be paid thereafter a flat monthly rate based upon the average cost incurred by providers in the region in furnishing services to such patients.

Updates

Both the per visit payments and the regional per episode caps would be computed initially on a base period and then updated annually based on the home health market basket index.

Non-Routine Medical Supplies

Non-routine medical supplies will be paid on a separate fee schedule which will cover acquisition cost and a flat percentage for handling. These payments will not count against the per episode cap.

Conversion to Pure Per Episode Reimbursement

Within three years of the implementation of this reimbursement system, the Secretary will provide a report to Congress concerning the conversion of this reimbursement system to a pure per episode reimbursement system based on information generated from the Phase II demonstration project.

Quality

Any prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing quality. The Secretary will ensure that the quality of services remains high by proceeding to implement a revised survey and certification process which emphasizes patient satisfaction and successful outcomes.

Home health agencies will be required to provide services to beneficiaries to the extent that those services are determined by the beneficiary's physician to be medically necessary.

Savings

Significant savings will be achieved by providing incentives for providers to become more cost effective by controlling the rate of expenditure growth and by reducing administrative costs both for the providers and for the government.

The plan achieves immediate, intermediate, and long term savings in the following ways:

First, immediate and continuing savings will be achieved by establishing per visit rates based on reduced cost limits.

Second, significant savings will be achieved beginning with the end of the first year through the application of the aggregate per episode cap.

Third, substantial long term savings will be generated by reducing the rate of expenditure growth through the use of the home health market basket index to update the per visit payment rates and the per episode caps.

Further savings should be achievable through reduced administrative costs both for providers and for the federal government for the following reasons:

1. cost reports could be reduced in complexity or eliminated entirely, and there will be no retroactive disallowance of costs, and, therefore, no reimbursement appeals;

2. intermediaries will be required to determine patient eligibility and coverage of only one skilled qualifying service in order for an episode to begin; therefore, there will be no retroactive claims reviews or denials and few appeals; and

3. intermediaries will be required to make medical necessity determinations for extended care cases, but all denials will be prospective only, thereby eliminating costly retroactive denials and appeals.

Additional savings will be achieved as providers lower their total payments to less than the per episode caps.

Effective date

This reimbursement system will be implemented no later than six months after the date of enactment.

* * * * *

Rationale

Per visit payment with a per episode cap was used in order to develop a plan that could be implemented immediately using currently available data and procedures while putting home health services on the path to per episode prospective payment.

The definition of an episode was borrowed from the Phase II demonstration project funded by HCFA in order to be able to use the data generated by that project over the next few years to improve and refine the prospective payment plan.

An aggregate per episode cap was employed in order to provide the government with control over expenditures while reserving clinical decisions to the provider, the physician, and the patient. It was also felt that this would be a low cost method of controlling the growth in spending.

A 45-day break in service between episodes was included in order to prevent providers from "gaming" the system by discharging and readmitting patients in order to generate more episodes. The providers' annual aggregate per episode cap is case mix adjusted to discourage providers from seeking to increase revenues by accepting only less acutely ill patients.

A savings sharing provision was included in order to discourage providers from maximizing their payments per episode in order to reach the cap.

A separate reimbursement method was established for patients who need acute care services over a long period of time to avoid creating an incentive for providers to cease treating these patients.

PREPARED STATEMENT OF DAVID N. SUNDWALL, M.D.

As President of the American Clinical Laboratory Association ("ACLA"), I am pleased to have this opportunity to introduce myself and to present ACLA's views on issues related to the growth in Medicare expenditures for clinical laboratory services. ACLA is an association representing the leading independent providers of clinical laboratory services, including national, regional and local facilities. All ACLA members will be significantly affected by any change that Congress makes in reimbursement for clinical laboratories.

As a practicing physician myself, I know how important clinical laboratory testing is to the delivery of quality health care services. Laboratory testing provides information to physicians about a patient's health status and is an essential tool in the prevention, diagnosis and treatment of disease. As a result, ACLA members believe it is vitally important to safeguard patients' access to quality laboratory testing. ACLA also recognizes, however, the importance of ensuring that clinical laboratory services are used appropriately, and in the most cost-effective manner possible.

This morning, I would like to make the following key points:

- Congressional limits on the price for laboratory testing, coupled with fundamental changes in the relationship between physicians and laboratories, have dramatically reduced utilization of laboratory services in recent years. The HHS Office of the Actuary recently reported a 3% decline in laboratory expenditures from FY 1993 to FY 1994.
- Second, ACLA recognizes that Congress is considering the imposition of a coinsurance requirement for clinical laboratory services. This option appears to be motivated, in part, by a perception—which is erroneous in ACLA's view—that imposition of coinsurance will limit utilization of clinical laboratory services. In fact, studies have concluded that because physicians, rather than patients, order testing, a copayment does not affect utilization of laboratory services, Further, imposition of copayment would be extremely inefficient with laboratories incurring collection costs of as much as 75-90% of expected revenues.
- Finally, to the extent this Committee is interested in reducing utilization and laboratory costs, we believe there are other more appropriate ways to reduce utilization (and reduce expenditures) than reinstitution of coinsurance. We will be happy to work with Committee staff to develop these options.

A. PAST CONGRESSIONAL EFFORTS TO REDUCE EXPENDITURES FOR LABORATORY SERVICES

According to recent reports, Medicare Part B expenditures for clinical laboratory testing done by independent labs and in physicians offices decreased by more than

10% between 1993 and 1994.[1] The 1995 Trustees Report also concluded that Medicare would pay slightly less for clinical laboratory services furnished by independent laboratories, per beneficiary, in 1994 than it paid in 1993. According to the Trustees Report, in 1995 the amount was expected to arise by only about 2.1%, and by 7.1% in 1996.[2] These reductions in the Medicare payments for laboratories do not appear to be fully reflected in the CBO baseline for laboratory services, but we expect that they will be when those numbers are recalculated in the future.[3]

Although clinical laboratory services constitute a relatively small part of the Medicare Part B dollar—approximately 5 or 6%—laboratories have sustained substantial cuts in reimbursement over the past ten years. The national limitation amounts have been reduced repeatedly since they were first established in 1986. In fact, laboratories are currently part way through a three-year reduction in these limitation amounts, which was mandated by OBRA'93. Those provisions reduced the national limitation amounts from 88% of the fee schedule medians in 1993 to 76% of the medians in 1996, and eliminated any inflation update for laboratory services for 1994 and 1995. These cuts amounted to a reduction of over $3.3 billion in laboratory payments over five years.

Moreover, it is important to emphasize that these cuts are not simply reductions in the future rates of increases, as has been true for some types of providers. While most providers have continued to receive fee increases, but at a level that is less than previously projected, laboratories have seen actual cuts in the payment amounts they receive. As a result of the changes imposed by OBRA'93, the amount that Medicare pays for a common clinical laboratory test went down by about 4.8% just between 1994 and 1995, and will go down another 5% in 1996. When the changes mandated by OBRA'93 are fully implemented, they will constitute a reduction of more than 14%. In summary, these cuts coupled with other regulatory changes, including implementation of the Stark self-referral law, have significantly slowed the growth of Medicare expenditures for clinical laboratory testing.

B. COPAYMENT WILL NOT REDUCE UTILIZATION. BUT WILL CONSTITUTE AN ADDITIONAL CUT FOR LABORATORIES

Despite the moderation in clinical laboratory expenditures, ACLA members recognize that this Committee is under an obligation to find additional ways to control the growth in the Medicare program. It is our understanding that members of Congress are seriously looking at reinstituting the 20% coinsurance requirement for clinical laboratory services, a requirement that was eliminated in 1984 (with the approval of HCFA and the laboratory industry) when the current fee schedule methodology was instituted. For the reasons explained below, ACLA objects to the reimposition of coinsurance requirement for laboratory services. We are especially concerned because it appears that some who promote this believe a coinsurance requirement will have an impact on utilization of laboratory services, which is unlikely to be the case.

For ancillary services, such as laboratory testing, imposition of a coinsurance requirement on Medicare beneficiaries does not curtail utilization because patients do not decide what clinical laboratory tests they need. Medicare-covered laboratory services can only be ordered by a physician, and the physician's judgment concerning whether or not to order testing is not likely to be affected by the fact that the patient may be responsible for a copayment. As the Congressional Budget Office noted in a 1990 report:

> Cost sharing probably would not affect enrollees' use of laboratory services substantially, . . . because decisions about what tests are appropriate are generally left to physicians, *whose decisions do not appear to depend on enrollees' cost sharing.*

A recent report by the Office of Technology Assessment came to a similar conclusion. Thus, to the extent that coinsurance is being considered in order to control utilization, its imposition will not have that effect.

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[1] "After Years of Soaring, Lab Utilization Plunges," *Laboratory Industry Report* at 1 (Vol. IV, No. 3) (May–June 1995). Part B also pays for outreach testing furnished by hospitals, but reliable data for that segment of the industry is not available.

[2] Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1995 Annual Report of the Board of Trustees* at 42 & 51 (1995) (hereinafter "1995 SMI Trustees Report").

[3] Other studies have also reported reductions in clinical laboratory services. For example, the Office of the Inspector General came to a similar conclusion in a recent report. While it noted that its data is incomplete, the OIG found that the rise in laboratory testing has slowed and that services performed in physician office laboratories have actually declined. See Office of Inspector General, CLIA's Impact on the Availability of Laboratory Services at 7 (OEI-05-94-00I30) (May 1995).

Second, imposition of coinsurance does not simply shift responsibility for the copayment amount from the government to the beneficiary—it represents a net loss for laboratories. Because the coinsurance amount is usually just a few dollars, the laboratory must often spend more to bill and collect the coinsurance than it receives in payment. For example, the national limitation amount for a Pap smear is $7.33. This is the maximum that Medicare will pay for that test, and in some instances, the laboratory is paid even less. If a 20% coinsurance were applied to this amount, then the laboratory would have to bill the patient for $1.47. If the laboratory has to bill twice to collect that amount, as frequently happens, the laboratory would have to spend 64 cents just in postage alone. When the additional labor and administrative costs are added in, the total average cost of producing a bill is about $3.00. Thus, it is easy to see that in many cases the cost of billing and collection will offset a significant portion of the amount the laboratory will receive in copayment.

Moreover, past experience has demonstrated that coinsurance amounts are very difficult to collect. Because the laboratory usually does not have contact with the patient, the beneficiary often does not know to what laboratory his or her testing is sent. Beneficiaries may, therefore, be confused when they receive a bill for some small amount from an entity with which they have no direct contact. As a result, the laboratory will likely have to write off a significant portion (50% or more) of the amounts billed due to the uncollectibility of these relatively small amounts. Indeed, these problems are the very reason that Congress eliminated coinsurance requirements in 1984 and mandated the current methodology. Further, the fraud and abuse laws mandate that the laboratory make reasonable efforts to collect the copayment, thus preventing the laboratory from simply writing it off without undergoing the expense of billing and attempted collection.

Because of the expenses associated with billing and collecting the coinsurance, reimposition of this requirement will actually result in an additional cut of as much as 15% for laboratories. This reduction, coupled with the 14% cuts mandated by OBRA'93, which are still being implemented, would amount to a substantial additional reduction in laboratory reimbursement. Such cuts will also make it more difficult for laboratories to serve higher cost areas, including rural areas and nursing homes.

Finally, reinstatement of coinsurance would also amount to a new burden on beneficiaries. According to recent estimates, reinstatement of insurance for laboratory services would transfer to beneficiaries additional aggregate outlays of approximately $7.2 billion over seven years. In sum, reinstitution of coinsurance will shift an unfair burden onto the elderly, and will force laboratories to spend more money than they are likely to collect.

C. THE COMMITTEE SHOULD CONSIDER ALTERNATIVES OTHER THAN COPAYMENT FOR CLINICAL LABORATORIES

ACLA believes that there are other, more appropriate ways to reduce utilization of laboratory services and control expenditures for clinical laboratory services than reinstituting copayment for laboratory services. We look forward to working with the Committee and the staff to identify several of these alternatives. In addition, there are other important measures which should be considered and implemented.

Direct Billing

We would like to take this opportunity to highlight several relevant issues that ACLA members believe should be part of any legislative package related to clinical laboratory reimbursement. The first relates to administrative simplification—direct billing. This is a requirement that the laboratory performing the test bill the patient or insurer for those services. This provision would simplify the billing structure of the industry and lead to a more rational market for laboratory services. Enactment of such a requirement would also promote a more cost-conscious and efficient system for the delivery of testing services than currently exists. [We are pleased that Congressmen Fred Upton and Sherrod Brown have introduced H.R. 1461, the "Direct Billing Act," which would require such a direct billing requirement. We hope members of this Committee will consider adopting a similar provision.]

Today, Medicare already requires direct billing for laboratory services; however, labs are not required to bill the patient or responsible third-party payor for non-Medicare testing. Billing physicians, rather than patients, promotes the practice of mark-up by physicians, resulting in higher costs to the patient or third-party payor. As reimbursement is reduced for the services that physicians provide directly for their patients, their selection of the laboratory, and the number of tests requested, tend to be influenced by the potential for additional income. In most cases, physicians, as wholesale customers, wield sufficient market power to demand and receive significant pricing concessions from laboratories, thus maximizing the potential for

mark-ups. The result is that physicians pay lower prices, while other retail payors pay for laboratory tests at a higher level. Direct billing will eliminate the underlying structural problem that leads to this cost-shifting.

Enactment of direct billing would have several important effects. Most significantly, it would result in reduced utilization of laboratory testing and lower costs as found in a recent study conducted by the Center for Health Policy Studies ("CHPS"). The CHPS study compared the experience of Medicare and Blue Cross/Blue Shield plans in direct billing and non-direct billing states. It found that laboratory prices and utilization were significantly higher in non-direct billing states than in states that require direct billing. The CHPS study also concluded that if a national direct billing law were enacted, annual savings in national health care expenditures of between $2.4 billion and $3.2 billion could be achieved, as a result of reduced utilization and lower prices.

In addition, the CHPS study also suggested that the enactment of direct billing could help reduce Medicare expenditures for clinical laboratory services. Although the Medicare Program already requires direct billing, the CHPS study found that Medicare utilization may also be lower when the state required direct billing for private payors. CHPS concluded that this reduction resulted from a "spillover effect"—that is, in direct billing states, physicians changed their ordering patterns for both Medicare and non-Medicare patients alike. As a result, utilization of clinical laboratory services reimbursed by Medicare was lower in direct billing states than in non-direct billing states. ACLA urges this Committee to consider the adoption of a direct billing law, comparable to H.R. 1461.

Uniform Ordering And Billing Policies

In addition, ACLA also believes that clarification and simplification of clinical laboratory ordering and billing would have a beneficial impact on the utilization of laboratory testing and help reduce unnecessary administrative costs for all parties. Such actions will ensure that physicians fully understand the impact of their test-ordering decisions—that Medicare pays only for appropriate testing—and that the Medicare program can adequately monitor and enforce its laboratory payment policies.

Because clinical laboratories do not order tests, it is the physician's responsibility to determine the testing that is medically necessary for his or her patients. ACLA believes, however, that laboratories must work with physicians to ensure that they understand the appropriate use of clinical laboratory testing and the impact of their test-ordering decisions on the Medicare program. Thus, ACLA has established guidelines that encourage ACLA members to explain the tests that are included in panels and profiles which are offered, and to provide physicians with information about how Medicare pays for the tests that are ordered. By working with the physicians in this way, ACLA believes that laboratories can help ensure that physicians understand the test they are ordering, and the financial impact of their decisions on the Medicare program. In the long run, ACLA believes that such increased communication between labs and physicians will result in more appropriate utilization of services.

Although laboratories continue to work with HCFA, encouraging them to promote simplified laboratory payment rules, labs are faced with increased administrative expenses because of the various and disparate billing requirements that have been imposed by many Medicare carriers. Laboratories are forced to spend more on administrative concerns and less on the actual provision of clinical laboratory services as a result of these requirements. Such an increase in administrative expense is especially difficult to justify at a time when Medicare payments are being significantly reduced.

Carrier Variation

In particular, many carriers have recently begun to impose their own policies requiring laboratories to submit documentation of medical necessity for various individual tests. In some instances, the carriers require that a numerical code describing the patient's condition or diagnosis, referred to as an ICD-9 code, be included as a separate line item on the requisition for certain tests. If the particular code is not one that the carrier recognizes as appropriate for the test ordered, then the payment to the laboratory is denied. Because only the physician can determine what tests to order and what codes to assign, however, it makes little sense to deny payment to the laboratory if the code is not submitted or if the code selected by the physician is not acceptable to the carrier. Moreover, these requirements result in an increase in the administrative costs borne by the laboratory. If a physician does not supply the appropriate information, as frequently happens, laboratories must contact the physician to try to obtain it. Because of other demands on their time

and the time of their staffs, physicians often object, justifiably, to such requests. Moreover, laboratories are often forced to hire additional staff whose only responsibility is to telephone doctors' offices to try to obtain the necessary codes. Furthermore, the requirements imposed by carriers vary greatly, thus further adding to the burden for independent clinical laboratories which do business in several different states.

Because of the difficulties in implementing such requirements, carriers end up denying more claims for services. This forces laboratories to go back to physicians to obtain additional information, so that the claims can be resubmitted. As noted above, such physician contacts add to the laboratories' expense. Further, such resubmissions are especially expensive for laboratories and Medicare carriers to process because they must usually be handled manually, rather than through electronic means.

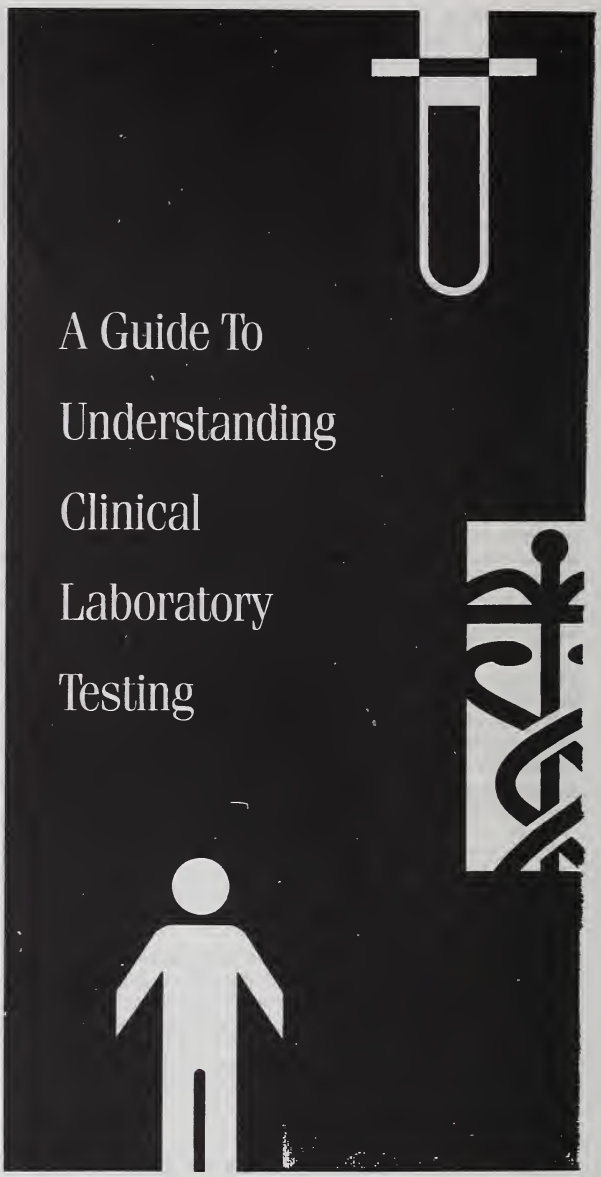
ACLA believes, therefore, that it would be very useful to eliminate the different rules and policies that apply to clinical laboratories in order to reduce administrative costs that result. Today, over 40 different carriers representing 59 different jurisdictions process laboratory claims. A large national laboratory with facilities in many locations now has to monitor and comply with different rules for each carrier jurisdiction. As described above, such differences on relatively basic issues lead to confusion and wasted effort by all parties, and increase the administrative costs associated with clinical laboratory testing. ACLA believes that administrative costs could be significantly reduced and procedures simplified if laboratories dealt with uniform coverage and payment policies. As a result, ACLA urges the Committee to require a consolidation of carrier responsibilities for laboratory services and the development of uniform policies with respect to coverage and payment issues. The enactment of such policies will reduce administrative costs not only for laboratories, but for the Medicare system. Moreover, such a system will reduce fraud and abuse concerns because it easier for labs to comply with a single uniform standard, and it will be easier for HCFA to monitor compliance with such a standard.

Conclusion

ACLA believes that past efforts by Congress have significantly reduced Medicare payments for laboratory services. We believe copayment will not affect utilization, but will result in an additional cut for laboratories. ACLA looks forward to working with the staff to identify other more appropriate ways to address laboratory payment issues, including direct billing and administrative simplification and greater uniformity among carriers.

Attachment.

ACLA



A Guide To Understanding Clinical Laboratory Testing

American
Clinical Laboratory
Association

The American Clinical Laboratory Association (ACLA) is a not-for-profit organization whose members include the leading providers of independent laboratory services in the United States.

What is clinical laboratory testing?

Clinical laboratory testing is an essential part of quality health care. It provides physicians with objective data needed to help promptly diagnose, treat and monitor disease. Appropriate testing enables a physician to make an early diagnosis and implement the correct treatment, which ultimately saves lives and reduces overall health care costs. Diagnostic data represents reliable and objective information related to an individual's health status. As such, diagnostic testing used appropriately is critical to the quality and utility of health care services worldwide.

It is estimated that in 1993 approximately $32 billion (or roughly 5% of total health care expenditures) was spent on clinical laboratory testing. In 1992, approximately 35% of laboratory testing was conducted by independent laboratories, 48% by hospital laboratories and 17% by laboratories located in physician offices. Together, these clinical laboratories offer more than 2,400 types of tests, provide the most advanced testing available anywhere in the world, and play a vital role in our nation's health care delivery system.

What are Independent Laboratories?

Independent laboratories are laboratories not located in a hospital or medical office, and which provide testing and related services to the medical community. With their focus exclusively on clinical testing, independent laboratories are able to offer a broad range of high quality services cost-effectively. These laboratories also are involved in developing new diagnostic capabilities thereby continually adding improved diagnostic services.

What is the American Clinical Laboratory Association?

The American Clinical Laboratory Association (ACLA) is a not-for-profit organization established in 1971 to advocate for public policies that support the essential role laboratory services play in delivering cost-effective health care, and to encourage the highest standards of quality, service and ethical conduct among its members. In addition to advocating for appropriate federal laws and regulations, ACLA seeks to educate the public and policy makers about the importance of laboratory testing in the early detection, diagnosis and treatment of disease.

To effectively communicate its mission to government leaders and the public, ACLA offers its members the benefits of federal government representation, education, information and encourages health services research related to clinical laboratories.

ACLA member companies include the leading providers of *independent* laboratory services in the United States. Currently, ACLA member companies employ approximately 75,000 clinical laboratory professionals nationwide.

Clinical Laboratory Market
(Estimated)

Source: Robertson, Stephens & Co., San Francisco, CA

Note: Based on 1992 figures

How are clinical laboratories regulated?

ACLA is Dedicated to Improving the Nation's Health Care System and Ensuring Access to Quality Care by:

- Encouraging the highest standards of quality, service and ethical conduct among its members;
- Providing a forum for members to exchange information about scientific developments and health care policies; and
- Advocating laws, regulations and public policies that support the unique, essential role that laboratory services play in the delivery of quality, cost-effective health care.

In 1988, Congress enacted the Clinical Laboratory Improvement Amendments (CLIA) which established stringent federal quality standards for all clinical laboratories. ACLA was an early and vigorous propónent of CLIA and continues to support its implementation.

ACLA Principles of Conduct

To achieve its mission, ACLA and its member companies recognize their obligation to advocate and adhere to ethical business practices. The following principles of conduct apply to all ACLA member companies' dealings with patients, payors, and the medical community. Each ACLA member company pledges to:

- Improve public health, well-being and safety.
- Provide accurate and timely laboratory testing in order to:
  - Aid in the prevention, diagnosis and treatment of disease;
  - Promote the maintenance of good health; and
  - Enable patients to receive the highest levels of care.
- Protect patient welfare and confidentiality by reporting test results only to those authorized by law to receive such results.
- Safeguard public health, occupational safety, and the environment.
- Conduct all business practices in a fair and ethical manner.
- Comply with all federal, state and local laws and regulations which govern the laboratory industry and its employees.

How does the testing process work?

Clinical laboratory testing is a three-way partnership between the patient, the physician and the laboratory.

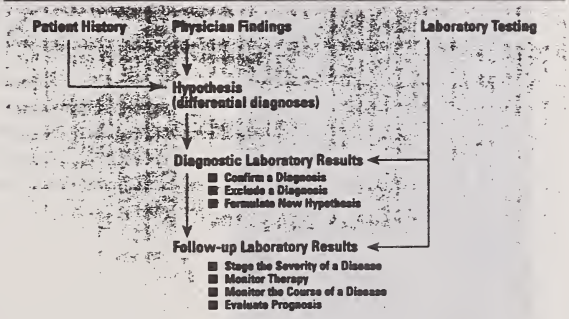
The patient selects a physician and shares his or her medical history. If the physician's evaluation requires laboratory tests, the testing is conducted either in the physician's office, a hospital laboratory or an independent laboratory.

Upon receipt, each patient specimen is uniquely identified and individually examined to make certain that it is appropriate for the requested testing. While some tests, such as a pap smear examination, are manually evaluated, most testing is performed using technically advanced, computer directed, instrumentation. For all patient testing, the laboratory employs a team of licensed, highly skilled medical professionals, specially trained to perform these analyses.

After testing is completed, the laboratory issues a report to the ordering physician.

While the clinical laboratory is the "silent partner" in this triad, it is extremely important for the doctor and the patient to discuss the results of the testing. It is only through doctor/patient discussion of normal and abnormal test results that appropriate treatment to address identified medical problems or disease prevention can be implemented.

Partners in Promoting Health: Patient, Physician, Laboratory



Case Study "36 hours in the life of a Primary Care Physician"

The following are real-life stories which demonstrate how the partnership between the laboratory, patient, and physician help patients achieve positive health outcomes. Laboratory tests are usually ordered for one of three reasons: diagnosis, screening or patient monitoring. Each of these cases exemplifies at least one of the key roles of laboratory testing.

Saturday afternoon - 3:00 p.m.

Diagnosing and treating an overdose of medications

A 22 year old woman, with a long history of emotional problems, made a serious suicide effort by ingesting multiple medications. She was found in a comatose state with no evidence of what she might have taken. Although the patient is an insulin-dependent diabetic, a suicide note found near her indicated that this was not a "diabetic coma."

At the hospital, blood was drawn immediately for laboratory work, including a toxicology screen to identify substances the patient might have taken. Test results confirmed that the patient had taken a combination of over-the-counter and prescription medications. The laboratory tests detected the chemical substances she ingested so that appropriate treatments were initiated in the form of antidotes and organ system-specific supportive care. The patient survived and was weaned off the respirator within 48 hours.

Sunday morning - 9:00 a.m.

Screening to determine if treatment is needed for an internal hemorrhage

A 65 year old gentlemen was struck by a car in a church parking lot, when a young woman who was attempting to park, inadvertently stepped on the gas instead of the brake. The victim was taken by ambulance to the community hospital emergency room, where it was determined that he suffered from multiple contusions and abrasions.

Blood was drawn immediately to help determine if there had been internal injuries which may have been apparent by a drop in the blood count (the hematocrit). It is customary in cases of trauma to also draw a vial of blood which can be used to "type" the patient's blood so it can be crossmatched for compatible blood in case a transfusion is needed. In this instance, no serious injuries were sustained, and no transfusion was required. However, unless the laboratory work is done immediately, it might be too late to effectively treat an internal hemorrhage by the time it becomes clinically apparent.

Monday morning - 10:00 a.m.

Diagnosing and monitoring tuberculosis

A 53 year old resident of a homeless shelter was found to have "converted" from a negative skin test for tuberculosis exposure to positive. A positive skin test indicated that some time during the past two years since his previous test, he had been exposed to tuberculosis and possibly infected. Further tests were necessary to document his status, including a chest x-ray to see if the patient had active pulmonary disease. The x-ray was negative, but current recommendations from the Centers for Disease Control (CDC) for treatment of a positive skin test for tuberculosis include taking isoniazid (INH) medication orally for six months. This particular drug has a relatively high incidence of liver toxicity, and it is necessary to have base-line data documenting liver function before it can be prescribed. Since this patient had a long history of episodic alcohol abuse, it was particularly important to have this information.

A chemistry profile was obtained, and if the laboratory tests indicate his liver functions normally, the INH medication will be started. He will need to be tested on a periodic basis to monitor his liver function and insure that the medication does not have any untoward side-effects.

Monday afternoon - 2:00 p.m.

Confirming a diagnosis and treating AIDS

A 37 year old man arrived at a clinic with a fever, cough, chills, sweats and weakness. Physical examination led to a presumptive diagnosis of full-blown AIDS. He had a fungal infection in his mouth, apparent pneumonia as evidenced by significant congestion in his lungs, and a diffuse non-specific rash.

Laboratory tests were drawn to confirm the clinical diagnosis. The tests included an HIV test, a complete blood count (CBC), and a "T-cell" count. This particular type of blood cell is typically suppressed in AIDS patients. Appropriate treatments were initiated for his infections and even if laboratory tests confirm he has AIDS, his symptoms will likely resolve within a few weeks. Prophylactic medications can then be started to limit his risk of future infections. The laboratory role in this instance is not only to confirm the diagnosis but also in the long-term monitoring of health and possible side-effects from medications.

What are the purposes of laboratory testing?

Evaluating Usefulness of Diagnostic Screening Tests

- Will the test detect disease that would otherwise go undetected until a later time?
- Will earlier disease detection have a favorable impact on patient status?
- What is the risk, cost, efficiency and effectiveness of therapy at an earlier stage of disease?
- How will earlier diagnosis affect the patient's psychological well-being?

Laboratory tests are usually ordered for one of three reasons: diagnosis, screening or patient monitoring.

Diagnosis

Clinical laboratory testing helps physicians pinpoint a patient's illness. Although the results of laboratory tests are not the sole factor in making a diagnosis, testing provides clues or patterns that help to reach a conclusion on a patient's condition. For example:

- The specific organism causing an infection, and the antibiotic that will be most effective to treat a particular organism, can be determined by laboratory tests.
- Laboratory tests help distinguish between possible causes for symptoms such as acute abdominal pain.

Screening

Screening is helpful in finding abnormalities whether or not symptoms are present. It also can be used to prevent the onset or spread of disease and can establish a "baseline" in the patient's medical history that can serve as a reference point throughout the course of the patient/physician relationship. For example:

- Routinely screening for cholesterol levels allows patients to take appropriate steps to avoid heart disease.
- Pap smears have reduced the number of cervical cancer deaths by 70-75% over the past 50 years.

Patient Monitoring

Over one-half of all clinical laboratory tests are ordered to monitor a patient's condition. These tests are used to track improvement or disease progression, to identify complications or side effects of treatment, to ensure that the most effective drug levels are being used, and to assess prognosis. For example:

- Diabetics can control their blood sugar level, often preventing kidney disease and blindness.
- Seizures can be effectively controlled when medications are taken in doses sufficient to maintain optimal therapeutic levels.

What do I need to know about laboratory testing?

Can things such as a patient's diet affect test results?

In some cases sensitive test results can be skewed by diet, stress, exercise, smoking, and medication. To minimize the possibility of incorrect test results, the patient must be properly prepared for the test, and the specimen properly cared for after collection.

Factors that can Affect Test Results

Patient Preparation and Specimen Collection
- Diet
- Time since last meal
- Smoking
- Stress
- Medications
- Time of specimen collection

Transport and Processing
- Collection container and preservative
- Transport conditions
- Storage prior to processing
- Processing conditions

Who performs a clinical laboratory test?

The 250,000 professionals who perform clinical laboratory tests are an integral part of the patient care team. In fact, they represent the third largest segment of the medical services industry. All laboratory professionals must meet the standards of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). ACLA members employ testing personnel who meet these standards and have the education, training and experience to perform their assigned tasks.

Laboratory professionals may be generalists, or may concentrate in specialized areas of medical testing. The following are examples of clinical laboratory specialists:

- **Pathologist** — a licensed physician who serves as a consultant to other physicians by supplying essential diagnostic information and expert medical opinion, particularly in the anatomic pathology areas of histology and cytology, and the interpretation of clinical laboratory tests.
- **Cytotechnologist** — a professional who examines gynecologic samples under the microscope, for the presence or absence of early signs of cancer or other diseases.
- **Medical Technologist** — a medical professional who works in the clinical specialties such as chemistry, immunohematology, hematology, immunology, and microbiology.
- **Histologic Technician** — a professional who prepares very thin sections of body tissues for microscopic examination by a pathologist.

How has the role of the laboratory changed in the past 40 years?

Examples of Life-threatening Conditions that can be Detected Early with the Help of Laboratory Tests

- Heart Disease
- Prostate Cancer
- Diabetes
- AIDS
- Kidney Disease
- Cervical Cancer
- Birth Defects

The second half of the twentieth century has been marked by enormous advances in medical science and technology. Among these advances, our understanding of biochemical and genetic processes affecting human health and disease has increased immensely. Clinical laboratories have used this new knowledge and the latest in medical technologies to make better, more specific, and more cost-effective tests available to physicians.

During the 1950's almost all clinical chemistry procedures were performed manually. The first comprehensive daily quality control program for laboratories was introduced in 1958. Later, quality control methods were improved and broadened to include quality assurance, reporting and data management. While computers first moved into the clinical laboratory in 1969, they proliferated during the 1970's and 1980's because of advances in technology.

Today, laboratory test results enable physicians to diagnose many diseases faster, more accurately and less expensively than was previously possible. In the past, physicians often were required to undertake a succession of more general — and less conclusive — tests to establish a diagnosis or monitor the patient's condition. Today's doctors, through the use of more accurate and specific laboratory tests, can frequently pinpoint the patient's disease or condition, resulting in fewer office visits or days in the hospital. In this manner, the modern clinical laboratory makes a significant contribution to reducing overall health care costs.

What is the future for clinical laboratories?

While the U.S. population as a whole is only expected to double from 1950 to 2050, the number of Americans over age 65 is projected to increase fivefold. Accordingly, increased attention will focus on preventable diseases associated with an aging population including cancer, stroke, diabetes, hypertension and cardiovascular disease. The combination of an aging population and an emphasis on prevention will have a profound effect on clinical laboratories due to the inevitability of increased demand for such services.

How will labs of the future differ from today's laboratories?

The future of clinical laboratories will increasingly center around computers and advanced technology. Test orders and specimen collection, processing and reporting are rapidly becoming computerized. Physicians will have greater access to computers to receive test reports quickly. Improved computer software will also allow a more thorough analysis of the testing data to improve individual patient treatment and expand the physician's understanding of disease processes. Compact, user-friendly instrumentation will permit testing at a patient's bedside, in the operating room, and at other locations, including self testing at home. Genetic testing will tell us more about our individual tendencies to develop specific medical problems before they become apparent.

Will there be a need for additional laboratory professionals?

The number of clinical laboratory technologists and technicians is not expected to keep pace with the demand for laboratory services over the next decade. Increased specialized testing — especially in the areas of cytogenetics, tissue typing, genetic testing and transplantation — will create new job opportunities for qualified personnel.

Definitions of Terms

Cytogenetics: testing performed to detect chromosomal abnormalities associated with inherited diseases

Genetic Testing: testing performed to determine the arrangement of DNA macromolecules associated with human disease

Tissue Typing: testing performed before organ transplantation to determine the degree of similarity between the donor and the recipient

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D.

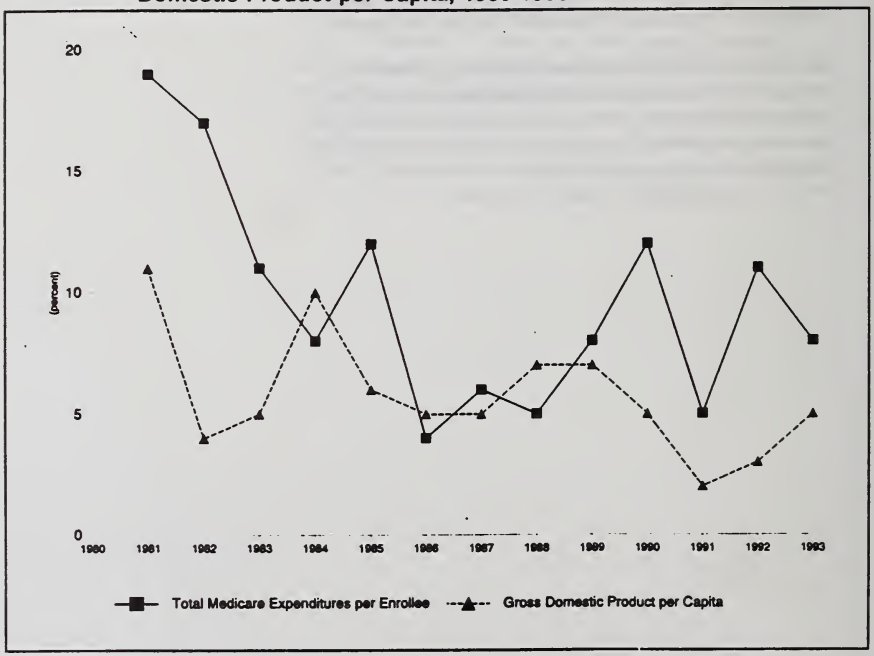
Mr. Chairman, I appreciate the opportunity to be here this morning to present the Physician Payment Review Commission's views on Medicare payment policies. Since it was established by the Congress in 1986, the Physician Payment Review Commission has devoted a substantial portion of its work to issues related to physician payment under Medicare. Our work assisted the Congress in shaping the Medicare payment reforms enacted in the Omnibus Budget Reconciliation Act of 1989 (OBRA89). We have followed up on that work by monitoring implementation of those reforms and by developing refinements to ensure that the policy meets the objectives of slowing expenditure growth, removing distortions in physician payment, and limiting beneficiary financial liability.

As this Committee considers Medicare reforms and takes on the challenge of reducing the federal deficit, it is important to understand recent trends in program spending and the impact of past policies on growth in price, volume, and total expenditures. My testimony today first reviews those trends and policies. It then considers the mechanisms that could be used to reduce future spending and options for legislative changes to accomplish them. Different strategies will be appropriate for the fee-for-service and managed care sectors. Moreover, any short-term steps should be consistent with the anticipated direction of more comprehensive reforms, particularly those that would permit Medicare to take advantage of the innovations in service delivery and payment that are now being used in the private sector. I will conclude my testimony by outlining projects now under way that will provide the Congress with information it can use as it considers these broader Medicare reforms.

BACKGROUND: TRENDS IN EXPENDITURE GROWTH

Overall, growth in Medicare expenditures are outpacing growth in gross domestic product (GDP) (Figure 1). Moreover, while Medicare spending grew more slowly than private health expenditures during the 1980s, since 1991, Medicare has grown substantially faster than spending in the private sector at 6.5 percent per capita versus 4.7 percent. More recent estimates from the Congressional Budget Office (CBO) suggest that this differential has grown with private spending growing at 5 percent in 1994 versus 10 percent for Medicare.

Figure 1. Annual Growth in Total Medicare Expenditures per Enrollee and Gross Domestic Product per Capita, 1980-1993



SOURCE: Health Care Financing Administration.

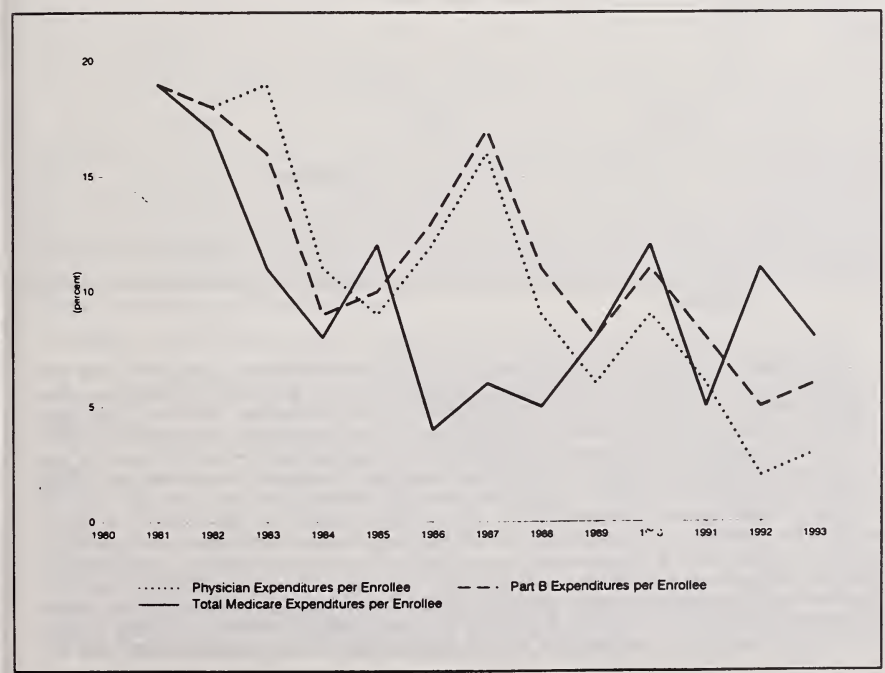
As you know, Medicare expenditures can be divided into Part A spending which covers inpatient hospital, skilled nursing facility, home health, and hospice care, and Part B spending which covers such benefits as physicians' services, laboratory services, durable medical equipment, and outpatient hospital services. Physicians' services amounted to $29 billion in fiscal year 1994, about 51 percent of Part B spending.

After extremely high growth during the 1980s, annual growth in Medicare expenditures for physicians' services has slowed considerably relative to the historical trend. Between 1986 and 1991, expenditures grew at an annual rate of 10.5 percent. By contrast, between 1991 and 1993, estimated expenditure growth slowed to an average annual rate of 3.8 percent (Figure 2).

Looking to the future, growth in spending for physicians' services is projected to rise once again. CBO projects that spending will grow slightly less than 10 percent in fiscal year 1995, followed by annual growth rates of 9 percent to 12 percent. Growth rates for other components of Part B spending, such as durable medical equipment, laboratories, and outpatient hospital services, are projected to grow even more rapidly, pushing annual growth for all of Part B to 12 to 13 percent through the end of the 1990s. While the Commission's mandate does not extend to these other areas of Medicare spending, the magnitude of spending on these services suggests the potential for savings. Over time, physicians' services have declined as a share of Part B spending (from 61 percent of spending in 1988 to 51 percent today) with outpatient hospital services and prepayment plans now representing 32 percent of the total.

Increased outlays for physicians' services can result from two sources: increases in payment rates and increases in the quantity or mix of services provided (often referred to as volume). Volume growth can be separated further into two components: those due to growth and aging of the population and those due to changes in the practice of medicine. While population growth is often mentioned as being a major cause of rising physician expenditures, in fact, its impact has been relatively small with Medicare beneficiaries growing at between 1.5 percent and 2 percent annually.

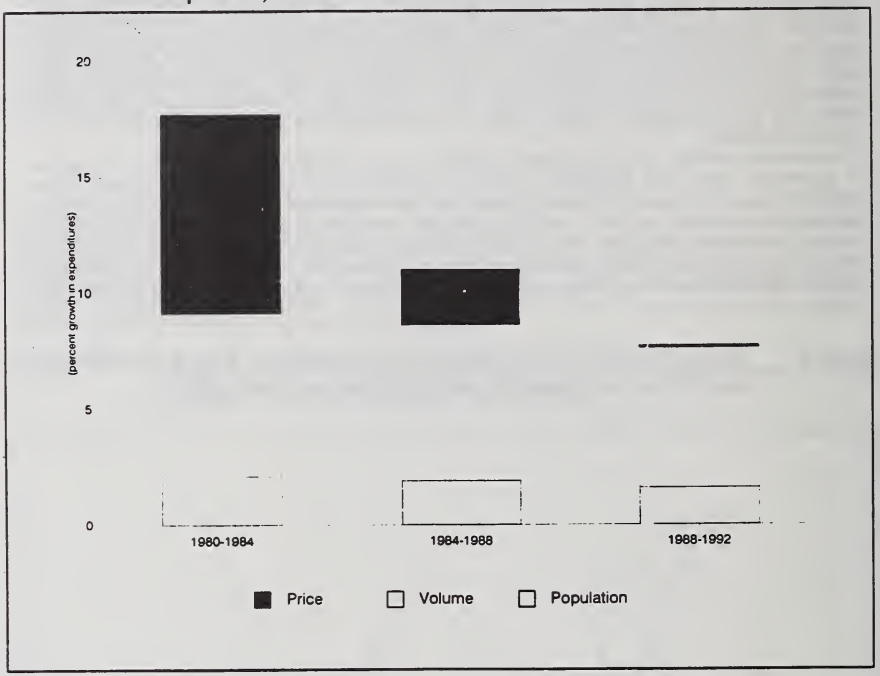
Figure 2. Annual Growth in Total Medicare Expenditures, Part B Expenditures, and Physician Expenditures, per Enrollee, 1980-1993



SOURCE: Health Care Financing Administration.

The distinction between growth attributable to price and growth attributable to volume is important for understanding past congressional action to slow spending. During the 1970s and 1980s, the primary policy levers to restrain Medicare expenditure growth were restraints on price, either through across-the-board fee freezes or via fee cuts for procedures that the Congress specified as overvalued. There were questions, however, about whether such price constraints could hold down expenditure growth over the long term. During the late 1980s, with these fee constraints in place, volume became the principal force driving up expenditures for physicians' services; from 1988 to 1992, payment rates accounted for about 0.1 percentage points of total growth in expenditures while the volume of services accounted for 6 percentage points of the 7.7 percent total growth in expenditures for elderly enrollees (Figure 3).

Figure 3. Growth in Medicare Physician Expenditures (for Aged Enrollees), by Component, 1980-1992



SOURCE: 1994 Annual Report of the Board of Trustees, Federal Supplementary Medical Insurance Trust Fund.

Two principal goals of the 1989 physician payment reforms are central to our understanding of the issues I will discuss today. The first goal was to eliminate distorted incentives and inequitable payments across specialties, services, and geographic areas. The second was to put in place a direct mechanism to contain volume in order to maintain program expenditures at a sustainable level. The policies enacted in OBRA89 to achieve these goals were the Medicare Fee Schedule, which bases payments on the relative resources used to provide different services, and the Volume Performance Standard (VPS), which links updates in the conversion factor of the fee schedule to growth in the volume and intensity of physicians' services.

In the years prior to implementation of the Medicare Fee Schedule, reductions in fees for overvalued procedures both helped slow expenditure growth and were consistent with the goal of moving toward resource-based payment. Once the fee schedule was implemented, however, achieving savings through further reductions in payments for individual procedures would distort relative payments under the fee

schedule. Therefore, the VPS mechanism became the primary mechanism for controlling expenditure growth.

The VPS system serves two purposes. First, it controls growth in spending by linking payment levels to the growth in volume and intensity of physicians' services. Second, it is intended to serve as a collective incentive to the medical profession to find ways to reduce inappropriate care, such as developing and disseminating practice guidelines that promote cost-efficient practice styles.

Under OBRA89, a performance standard (essentially a target rate of expenditure growth) is to be set annually either by the Congress after consulting with the Commission and the Secretary of Health and Human Services or by a default formula specified in law. (In fact, the default formula has been used in most years.) Then payment rates are adjusted in subsequent years as actual expenditure growth exceeds or falls below these standards. Performance standards were first applied to physicians' services in 1990; fee updates based on how well physicians met these standards were first applied in 1992.

Although the Commission had recommended a single performance standard, OBRA89 created a system with two: one for surgical services and one for nonsurgical services. A third standard (primary care) was added under OBRA93 in response to concerns that growth in volume for technical procedures in the nonsurgical service category was depressing fee levels for primary care. Because differential updates based on these three standards are determined for each service category, relative value units in different categories are not paid the same amount. As a result, relative payments have become distorted (Table 1). This violates the basic principle underlying the resource-based relative value scale, namely that each relative value unit should be worth the same amount regardless of the service to which it is attached.

Table 1. Conversion Factors, 1992–1995 (dollars)

Category of Service	1992	1993	1994	1995
All Services	31.00	.....	.....	.....
Surgical	.....	31.96	.....	.....
Nonsurgical	.....	31.25	.....	.....
Surgical	.....	.....	35.16	39.45
Primary Care	.....	.....	33.72	36.38
Other Nonsurgical	.....	.....	32.90	34.62

SOURCE: Physician Payment Review Commission compilation of conversion factors as reported in the Federal Register.

Beginning in 1992, volume growth slowed substantially. As a result, Medicare fee updates for 1994 and 1995 were much larger than had previously been anticipated (Table 2). The reasons for this slowdown in growth are unclear as are the prospects for its continuation. Possible explanations include some response to the incentives created by the VPS mechanism and secular changes in the practice of medicine. The latter include slowed growth in technologies and more efficient practice styles as a result of the increased penetration of managed care. Low volume growth in recent years may also merely reflect its inherent volatility. In fact, the trend probably reflects a combination of these factors.

Table 2. Conversion Factor Updates for 1992 through 1995 (percentage)

Categories of Service*	1992	1993	1994	1995
All Services	1.9	1.4	6.8	7.7
Surgical	.....	3.1	.....	.....
Nonsurgical	.....	0.8	.....	.....
Surgical	.....	.....	10.0	12.2
Primary Care	.....	.....	7.9	7.9
Other Nonsurgical	.....	.....	5.3	5.2

*A single update for all services was made in 1992, separate surgical and nonsurgical updates were required in 1993, and a separate update for primary care services began in 1994.

SOURCE: Physician Payment Review Commission compilation of final updates from Federal Registers.

Efforts to limit future Medicare spending for physicians' services may focus on either the fee-for-service sector, still the predominant form of payment under the program and the option chosen by over 90 percent of beneficiaries, or on expanding enrollment in managed-care plans in anticipation that such systems of care will be more efficient providers. Efforts to attain savings in the short-term, however, should not lose sight of structural problems that could impede achievement of policy goals in the long-term. Specifically, changes in the VPS are needed to ensure its ability to control the rate of volume growth in fee for service should it begin to rise again. Changes in the method for paying managed-care plans are needed to enhance their willingness to participate in the program. The Commission has suggestions in each of these areas that would enhance program performance and help it capitalize on innovative changes in the marketplace.

Another area of potential savings is Medicare funding for graduate medical education (GME). Since the Commission's mandate was expanded in 1990 to include consideration of Medicare financing of graduate medical education, we have developed substantial expertise on these issues, particularly with regard to Medicare payments for the direct costs of medical education. Budget cuts in GME raise serious questions about the appropriate role of the federal government in financing physician training. While the Commission does not have specific recommendations regarding such cuts, we stand ready to provide you and your staff with advice on the implications of different alternatives.

The Commission recognizes the difficult task this Committee will face given that Medicare policy changes must come in the context of substantial budget savings. We stand prepared to advise you as you work toward these two objectives. Traditionally, the Commission has not commented on the overall magnitude of Medicare savings. Instead, we take as our assignment the following: if the Congress should decide to reduce spending, how can that be accomplished in a way that is most consistent with long-term policy goals.

Fee-for-Service

In the past, proposals to slow growth in spending focused on selective changes in relative payments for certain services (for example, so-called overvalued procedures). While this was a reasonable strategy during the years of transition to a new payment system, it is not appropriate now that the Medicare Fee Schedule and Volume Performance Standards are in place. Making such cuts now would threaten the integrity of the fee schedule's resource-based relative value scale. This is a problem not only for Medicare but for the many private payers and Medicaid programs that use Medicare's relative value scale. Instead, payment policy changes should focus on changes in the conversion factor or on setting the performance standard. Either of these approaches would decrease fees across the board, rather than changing payments for specific services.

Given the large fee updates awarded in 1994 and 1995, the Congress may be inclined to achieve budget savings by rescinding previous fee updates or by making further adjustments to the VPS default formula. It is the Commission's view, however, that technical problems with the default formula used in setting volume performance standards should be corrected first. This is because despite recent high updates in Medicare fees, the current policy as written will result in substantial reductions in the conversion factor over the next five years for unintended reasons. In fact, conversion factors in 2003 are projected to be lower than when the policy was first implemented in 1992, even without accounting for inflation. Moreover, continuation of three performance standards will lead to further distortions in payment rates.

Once these problems are addressed, then an across-the-board cut in the conversion factor or reduction to the performance standard could be considered as a means of budget savings. For example, the size of the cut could be set so it would be comparable to rescinding part or all of the 1994 and 1995 updates. If Congress decides to take this approach, however, it should be mindful of the level of Medicare fees relative to those of private payers and the implications for access to care. These issues are considered below.

Fixing the Default Formula. The current VPS system has several flaws. First, under OBRA89, performance standards are determined in part by the historical trend in volume growth. At the time the law was written, historical trends were viewed as including some amount of inefficiencies and inappropriate care and therefore a decision was made to reduce the performance standard accordingly. Initially, deductions of one half of a percent were taken, phasing in over time to two percentage points. Under OBRA93, the deduction was increased to four percentage points.

The problem is that this deduction is now permanently embedded within the default formula and applies even as the 1991 to 1993 growth rate is the lowest two-year growth rate since 1985. In effect, the formula demands that however well physicians did in meeting the previous standard, they must reduce volume by an additional 4 percentage points each year or pay a penalty in reduced fees. Clearly, it is impractical to expect that physicians will continue to achieve such reductions year after year.

The combination of the four percentage point deduction enacted in OBRA93 and a lower-than-anticipated volume growth rate may make it extremely difficult to get additional savings by reducing physician payment. Since it is unlikely that volume growth will fall four points below current levels, maximum deductions in fees are already expected to be taken beginning in 1998 and continuing through 2002.

The bottom line is that changes in the VPS default formula are urgently needed. To address this problem, the Commission recommends replacing the current formula (historical trend in volume and intensity minus four percentage points) with a formula linked to the projected growth of real GDP per capita. This would permit a reasonable rate of growth that is affordable over the long term.

The Commission also recommends that to ensure the integrity of the resource-based relative value scale, a single performance standard and update for all physician services should be adopted. Currently, surgical services receive $39.45 for each relative value unit, while primary care services receive $36.38 and other nonsurgical services receive $34.62. And if the default formula is used to determine the fee updates for 1996, this distortion will be increased. In fact, primary care services will face a negative update of −2.2 percent, while surgical and other nonsurgical services will receive increases.

In its 1995 annual report, the Commission also recommended some additional changes in the VPS policy. As these are of a more technical nature, I will not discuss them today but only mention that these have been brought to the attention of Committee staff.

The Gap between Medicare and Private Fees. According to the Commission's analyses, Medicare fees are estimated to be 68 percent of those paid to physicians by private payers. The gap between Medicare fees and those of private payers in 1995 is less than the Commission reported last year because of higher Medicare fee updates, reduction in the trend for private fee growth, and more accurate data on private payment rates. The gap between Medicare and private fees should be considered when making policy changes because large differentials in payment between Medicare and private payers, coupled with discontent about Medicare's level of payment, could compromise access to care for Medicare beneficiaries. Even if the payments cover the cost of care, physicians may prefer to accept patients with private insurance over those with Medicare.

The Commission has not found, however, that the current gap is causing an access barrier. While it is possible that a substantially larger gap could affect physicians' willingness to treat Medicare patients, the size of that threshold is unclear. Moreover, it is possible that the gap between Medicare and private fees is narrowing as a result of fee discounts sought by private purchasers.

Managed Care

As the health system has moved toward managed care and integrated delivery systems, both the willingness of HMOs to participate in the Medicare program and beneficiary enrollment in these plans have grown rapidly. The number of managed-care plans with Medicare risk contracts increased by over 80 percent from the end of calendar year 1990 to the end of calendar year 1994, and enrollment increased by about 85 percent during the past 5 years. Currently about 9 percent of Medicare beneficiaries are enrolled in HMOs. About 75 percent of enrollees are in HMOs with risk contracts that are paid on a per capita basis; the rest are in plans with cost contracts that are paid based on "reasonable costs."

Fully three quarters (74 percent) of Medicare beneficiaries now live in an area with a Medicare managed-care plan available to them. But enrollment rates vary considerably across the country, with higher rates tending to occur in areas where commercial HMO penetration is high. Almost one-third (28 percent) of those Medicare beneficiaries living in California and Arizona are enrolled in risk contract HMOs. By comparison, 15 percent of those in Florida receive care from HMOs and just 5 percent of those in Massachusetts and Texas.

Further expansion of managed care within the Medicare program will depend upon several factors: the capacity of HMOs to accommodate elderly and disabled patients, plans' willingness to do business with the program, and beneficiaries' willingness to receive care under these arrangements. Plans' ability to attract and retain Medicare beneficiaries and beneficiaries' comfort level with managed care will likely

grow over time, particularly as individuals now covered by managed-care plans age into the program. At the same time, Medicare could encourage greater plan participation and ensure that the cost savings achieved as a result of managed care efficiencies accrue to the Medicare program by reforming its methods for paying HMOs.

Changes in this payment methodology are urgently needed and should be considered a first step in encouraging a more substantial role for managed care within Medicare. The Commission has made a number of recommendations in this area which would enhance program performance and help Medicare capitalize on innovative changes in the health care market.

The Problem. Current Medicare payment policies for HMOs are fundamentally flawed, and have contributed to problems of limited HMO participation (and thus low beneficiary enrollment rates), and higher costs per enrollee than their fee-for-service costs would have been. These problems include:

- the linking of managed care payment rates to Medicare fee-for-service expenditures, so that the cost efficiencies achieved by HMOs do not result in savings for Medicare;
- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- highly volatile county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

The Solutions. In the Commission's view, the first step in expanding managed care should be improving payment policy for risk contracts by correcting flaws in current capitation rates (referred to as adjusted average per capita costs or AAPCCs). If Congress fails to address these problems, a greater role for managed care will not necessarily lead to cost savings. Building upon this foundation, additional managed-care choices (such as preferred provider or point-of-service options) can be offered. In addition, other approaches that would create competition among fee-for-service and managed-care options within Medicare should be explored.

Capitation payment rates should be improved so that they (1) cover costs of an efficient HMO, (2) are better adjusted for risk selection, and (3) are more predictable from year to year. The Commission suggests two approaches for improving capitation payments: competitive pricing methods and refinements to the current AAPCC geographic adjustment method. Because competitive pricing would be effective only in markets with more than one HMO, both approaches are needed in the short-term.

Also needed are payment adjustments that mitigate the financial impact of adverse risk selection (having a patient population with higher than average health care use) and reduce the incentives for HMOs to select good risks. Since current risk adjustment methods are inadequate, partial capitation methods that base HMO payment partly on a capitation rate and partly on actual experience could also be tested. Reconsideration of the 30-day enrollment policy should also occur. These are discussed below.

Competitive Pricing. Competitive pricing would uncouple HMO payment rates from expenditures in the fee-for-service sector, using market mechanisms to establish payments that reflect the costs for an efficient HMO. The process could work as follows. First, HMOs meeting the qualifying conditions for risk contracts would submit offers of the minimum payment rate they would be willing to take. Then the Health Care Financing Administration (HCFA) would establish a payment rate based on the bids submitted. To create incentives for plans to bid low, plans that bid higher than the final rate should be penalized, perhaps by requiring these plans to charge the balance of their bid to beneficiaries in the form of premiums.

Whether Medicare would save money from using competitive bidding would depend upon how the final payment rates established from the bidding process compare with the level of the AAPCCs in those markets. Because it is not clear how competitive bidding might affect Medicare costs, some have proposed using payment limits—for example, using the national average per capita cost, adjusted for local input prices, as an upper limit. This approach is not ideal, however, because it would reintroduce the very problems that competitive pricing was intended to correct and would distort competition by preventing the established price from reflecting local market conditions.

There is a risk that the use of a competitive bidding system might place HMOs at a competitive disadvantage with Medicare fee-for-service. Policies to encourage fair competition between fee-for-service and HMOs in markets with competitive bidding may be crucial so as not to discourage the growth of managed care or bias the system toward the fee-for-service program. Such policies would involve restructuring

payment for the fee-for-service program, so that beneficiaries' payments for all types of options—HMOs and fee-for-service—would reflect payment rates established by bidding.

To enhance prospects for successful implementation, the Commission recommends that HCFA be given sufficient authority and flexibility to introduce competitive bidding in markets with the best chances for success (e.g., those with high HMO penetration) and, if successful, gradually increase the number of markets as competitive conditions change.

Refinements to the AAPCC Geographic Adjustment Method. Because competitive pricing would be effective only in markets where multiple plans can compete for Medicare business, AAPCCs or some other form of administered payment rates will be needed for the foreseeable future. AAPCCs also might be used during an interim period in locations designated for competitive pricing, until the new method was ready to implement.

Adjustments are currently made for differences in costs across geographic areas by taking the ratio of county-level per capita costs to the national average. This method is flawed because it establishes payment rates that are unstable over time and are susceptible to extreme geographic variation in service use patterns. It also creates an incentive for HMOs to choose to serve those counties within their service area with the highest payment rates.

Theoretically, geographic variation could be addressed by making payment adjustments that recognize input price factors that HMOs cannot control, such as local wage rates, and the portion of service use variation that is attributable to differences in health status. The current AAPCC reflects all service use variation, a portion of which reflects service underuse or overuse, and we are not able to measure the individual components accurately. Until more direct measures are developed, the Commission has recommended that a blended AAPCC be used, which is a weighted average of the AAPCC and the national average per capita cost (USPCC) adjusted for local differences in input prices.

To reduce payment volatility, two possible approaches are suggested. The first is to define geographic areas with larger Medicare populations to obtain a more stable base of health care expenditures for calculating AAPCCs. The second is to use a statistical technique (called a shrinkage estimator) to establish county-level payment rates that are based partly on the county's AAPCC and partly on the payment rate for a larger area that contains the county.

Partial Capitation. When an HMO assumes full risk for its enrollees' health care costs under capitation, its financial results could range widely from large gains to large losses. Partial capitation would minimize these potential swings by having Medicare share risk with HMOs that had losses or gains outside specified thresholds. Two different partial capitation methods could be used: (1) blended rates based on a weighted average of a capitation payment and fee-for-service payment for actual health care services provided, using existing Medicare fees, and (2) risk corridor payments that would adjust capitation rates in proportion to an HMO's net financial gains or losses exceeding established thresholds.

Although this is a promising solution, partial capitation could be difficult to administer. Before this method is widely used, therefore, demonstrations are needed to test different models and their data requirements for HMOs, and to develop needed information for setting risk thresholds and risk sharing percentages.

Enrollment Policy. In addition to the changes in payment policy described above, the current enrollment policy with its lack of coordination in enrollment periods may have contributed to low enrollment and risk selection. The Commission is recommending that a more structured enrollment process be established that provides for coordinated open enrollment periods. Also critical is a process for furnishing beneficiaries with objective, comparative information to allow them to make informed choices for HMO enrollment. Permitting beneficiaries to disenroll at the end of any month allows them to leave managed-care plans more freely than is common in the private sector and may result in disenrollment when they require more services. This policy should be reevaluated, weighing benefits of reducing opportunities for risk selection by locking beneficiaries in over a longer period against the risk of beneficiaries being unable to "vote with their feet" in response to poor service and quality.

The Role of Cost Contracts. Cost contracts have long been made available for HMOs that do not want risk contracts. While this flexibility has ensured that a range of options is available to Medicare beneficiaries, it has also contributed to favorable selection for risk contracting HMOs with increased costs to Medicare. In markets where competitive pricing is implemented, cost contracts should not be available. If a choice of contracts is offered in other markets, HMOs should be required to commit to the contract form they choose for more than one year.

FUTURE WORK

In addition to these recommendations, the Commission will be in a position to offer this Committee and others in the Congress additional advice concerning improvements in the Medicare program related to both the fee-for-service and managed care sector over the next few months. Among the analyses now under way are:

- Setting capitation payments for the risk contracting program. These analyses will extend the Commission's previous work by identifying potential markets where competitive bidding would be feasible, designing a bidding process and the structure of premiums for high bidders, and considering how to establish payment rates in areas where competitive bidding is not applicable. The Commission will also update its assessment of risk adjustment methods. In addition, it will analyze regional variation in benefits offered to Medicare HMO enrollees resulting from the current structure of payment policy.
- Structuring choices for Medicare beneficiaries. Questions of interest include the range of options that could be made available; whether there should be financial incentives for beneficiaries to choose more cost-effective options and how those incentives would be structured; and identification of statutory barriers to managed care growth.
- Techniques to better manage Medicare fee-for-service. Options to be pursued include case management, bundled payments, and risk-based carve-outs. The Commission has also contracted for a survey of Blue Cross-Blue Shield plans to determine the best practices for controlling utilization under fee-for-service arrangements.
- Access to care for Medicare beneficiaries. Building on the Commission's previous work on access, a strategy will be developed for monitoring access for those enrolled in managed-care plans. In addition, a survey will be fielded to explore the experiences of beneficiaries enrolled in or disenrolled from HMOs as a baseline for future monitoring.

CONCLUSIONS

I have focused my testimony on issues related to Medicare's current physician payment policies. Constraining Medicare spending growth will require a reexamination of each of the elements of the current program as well as consideration of potential ways to restructure the choices available to beneficiaries.

This past year, the Commission focused on changes in the VPS system and on improving the methods of paying HMOs. These reforms, however, are only part of a strategy to improve performance of the Medicare program. When Medicare was enacted thirty years ago, its design was meant to reflect the existing health care financing and delivery system. That system, however, has undergone major changes. Employers are fundamentally altering the way they purchase health services. Managed-care plans are growing rapidly and evolving towards more integrated systems of care. Physicians and hospitals are joining together in new types of organizations, transforming the way care is delivered.

These developments, along with the financial pressures facing the federal government, are bringing Medicare to a crossroads. It can remain the last open-ended program dominated by fee-for-service payment and unrestricted choice of providers or it can be restructured to reflect the rapid evolution of the market in the choices it offers and the incentives it creates for beneficiaries to choose more cost-effective options. The challenge that lies ahead will be to expand the number of choices available to beneficiaries and encourage the use of cost-effective providers, and to do so in ways that protect the fiscal integrity of the program and preserve beneficiaries' access to high-quality care.

PREPARED STATEMENT OF PAUL WILLGING, PH.D

Mr. Chairman, members of the committee, I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA), a federation of 51 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationally. On behalf of AHCA's members, and the one million plus residents of our member facilities, thank you for the opportunity to speak at this important hearing.

Over the last several years, as you have noted, spending on skilled nursing care under Medicare has grown more than most other providers, with the exception of home health care. However, according to ProPAC, since 1990, the total share of national health payments for nursing facility care has declined from 8.2% to 7.9% of health expenditures, while hospitals have gone up slightly and home health has in-

creased by 50%. While still representing a very small proportion of overall Medicare spending, less than 4%, skilled nursing facility (SNF) care under Medicare is growing for a logical and beneficial reason.

SNF GROWTH IS BENEFICIAL TO REDUCING SPENDING

Foremost in explaining the growth in post-acute SNF services are the demographics of our aging population. The number of elderly Americans is growing each year, mortality is dropping and it is estimated by the Congressional Budget Office that the number of seniors over 85 years of age will increase from 3.4% of the population in 1991 to 15.3% in 2050. It is essential that skilled nursing services be available to a growing, more acute, senior population and that we maintain and improve access to services where access may be lacking. There are still an estimated 2.9 million patients in acute settings per year that could or should be treated in a less restrictive and more cost-effective skilled nursing setting. As you will note from the accompanying chart, population is the largest factor in the growth of SNF spending.

Mr. Chairman, another explanation for SNF spending growth is the higher acuity of SNF subacute patients. As our patient population ages and becomes sicker, and we move more patients into residential care and assisted living facilities, SNF spending will continue to grow. This also corresponds to reduced lengths of stay in acute care settings which is a desired result from the implementation of the Medicare hospital Prospective Payment System (PPS). This factor is discussed on page 123 of ProPAC's June report to Congress where the Commission points out the correlation where states with low inpatient hospital costs correspondingly have higher SNF utilization. References in this report to reduced hospital stays and service mix changes for SNFs on page 69 also bear out this perspective. It is clear that patients are discharged sicker and quicker from hospitals and much of this can be attributed to SNF growth in quality and cost-effective subacute care.

Skilled nursing facilities offer subacute health care services at an average cost of 47% less than hospital-based SNFs. A report by Abt Associates, Inc. issued in June of 1994, identified 62 DRGs where SNFs are currently providing subacute care and estimated potential cost savings to Medicare if percentages of patients in these groups were treated in SNFs rather than in hospitals. Abt found a potential savings to Medicare of between $7.5 and $8.9 billion per year depending upon accounting for empty hospital beds and partial waiver of the 3-day stay rule.

I recommend that the Finance Committee examine the Abt report in detail to see how legislative initiatives proposed by AHCA could potentially save billions of dollars to the Medicare program. In short, as SNF spending increases on Medicare subacute care, there is a corresponding decrease in acute care spending, especially for outlier patients. This is a matter that ProPAC does not attempt to quantify but which they do acknowledge in their report.

While it is difficult to prove that subacute SNF days are replacing acute hospital days, perhaps there is a tell-tale sign in baseline budget figures released by CBO this year. CBO shows the hospital growth rate increasing at substantially less than previously predicted while the SNF growth rate in dollars is increasing correspondingly, faster. Since SNF spending is a small fraction of hospital spending, it makes sense that a small decrease in the anticipated growth in the hospital baseline would show a larger increase in SNF baseline spending if SNFs were competing for, and being utilized more, for subacute patients.

Probably the most important item to look at in terms of the growth in Medicare spending is what are the components of that growth. Our data department ran a comparison of skilled nursing facility expenditures for 1993 and 1994 and found the following:

- Of the factors accounting for the increase from 1993 to 1994 in SNF spending, population accounted for largest amount of the increase compared to utilization and price. Of the $1.3 billion increase, population accounted for $800 million or 62%;
- Of this increase, the costs attributed to price increases, which include the costs of treating patients of higher acuity than in the past, showed an increase accounted for only $300 million. This corresponds to an increase in price that is approximately 35% less than the rate of hospital price increases. Clearly our sector specific prices are going up at a slower rate than hospitals;
- The average length of stay dropped for hospitals and increased for nursing facilities which corresponds to the higher acuity of our patients and entry into subacute care;
- The intensity of services for SNF care increased cost an average of 5 cents—more of an increase per patient over hospital patients, again showing an increase in acuity.

Overall, in examining growth in our costs as an industry, it is not because we are increasing prices and are too profitable, but more clearly because of population demographics and because SNFs are aggressively competing in the health care continuum to treat subacute patients in more cost-efficient settings. Market forces are utilizing SNFs to substitute for more expensive acute care settings—especially managed care which I will discuss later.

And now, let me outline some of our proposals addressing cost containment which I know is of the utmost importance in attaining a balanced budget.

AHCA COST CONTAINMENT PROPOSALS

SUBACUTE CARE: POTENTIAL SAVINGS—$46 Billion

I have previously mentioned the Abt study that found a potential of up to $8.9 billion per year in subacute care savings to Medicare. AHCA proposes that hospital subacute DRGs be examined and rebased according to severity of illness and length of stay. Particular attention should be paid to the relative costs of SNF subacute care compared to hospital-based subacute care. For instance, HCFA's estimate released this year found that hospital-based SNF care is on average $88 per day more expensive than identical care in a free-standing SNF. It is absolutely clear, however, that SNFs can provide subacute care at substantially lower costs than hospitals. In order to test this, AHCA proposes that the Secretary of Health and Human Services immediately waive the 3-day hospital stay requirement for patients in a group of five DRGs, including skin ulcers and chemotherapy. Doing so would achieve an estimated $500 million per year in savings in just a few years. The SNF stay would be allowed only as a substitution to a hospital stay as certified by the admitting physician.

If you will refer to the chart which details DRG #410, chemotherapy without acute leukemia, Abt Associates estimates that no prior-three day hospital stay would be required for over 50% of all patients with this treatment need admitted to hospitals. Under current law, a hospital would receive a full DRG payment of approximately $4,121 for this type of patient, and could, if it wishes, transfer the patient to a hospital-based SNF unit and receive cost-based reimbursement of another $1314 on top of the DRG. In fact, across the nation, hospitals are legally maximizing reimbursement—some call it double-dipping, for thousands of their patients.

In contrast, AHCA proposes to eliminate this double-dipping ability, or in many cases, simply bypass the hospital altogether at a savings of approximately, in the case of DRG #410, perhaps as much as $4,000 per patient.

It is very important that CBO give this proposal a detailed analysis and not shrug off mention of the 3-day stay rule because of prior concerns when the Medicare Catastrophic Act was enacted and soon after repealed. We are talking about direct substitution for acute hospital stays and not the creation of new patients coming out of the so-called "woodwork" or any new subacute care benefit.

PROSPECTIVE PAYMENT: POTENTIAL SAVINGS—$1 Billion

Our second proposal involves redesigning the Medicare SNF payment system from a retrospective cost-based system to a prospective payment system (PPS). I want to express our appreciation, Mr. Chairman, for the support from your committee for our proposal in the past. In particular, Senators Dole, Daschle, Hatch and Pryor have supported this concept in their legislative initiatives. Indeed, Congress has twice before requested in OBRA'90 and again in OBRA'93 that we move to a PPS by October of this year. HCFA promised the House Ways and Means Committee in testimony during late 1993 to have an interim system to the Congress by last June. We are pleased to continue to work with them on a cost-containing prospective payment system, and believe that a model PPS system would be ready to implement by 1997 or 1998.

AHCA is very serious about curtailing administrative costs and building in incentives to save Medicare dollars. We support a case-mix, facility specific PPS that addresses costs in five costs centers: nursing services, administrative costs, fair rental value for property, ancillary services, and therapy services. In regard to current billing practices for medical equipment and ancillary services, we desire strongly to work with HCFA and the Congress to eliminate any fraudulent billing for such items. In addition, we have been meeting and working with HCFA on salary equivalency issues and will briefly discuss a cost-savings proposal to address problem billing practices that have been identified by GAO and the Inspector General. In short, AHCA's model PPS is designed to be revenue neutral, with incentives built in to control future costs, and we believe that it could be designed to curtail unnecessary billings for equipment or special services and significantly reduce utilization.

Our model PPS is designed to promote quality care; to ensure equal access for high-acuity beneficiaries; maintain adequate capital formation to address future demographic trends; and achieve cost containment. In the past, Congress has requested a PPS for SNFs, and HCFA has promised to develop one. We would request that HCFA honor its word with a balanced and constructive PPS that can be implemented by 1998, and we encourage this Committee to provide a statutory requirement to do so.

CONSOLIDATED BILLING: POTENTIAL COST SAVINGS—Undetermined

In order to respond to reports of billing abuses by providers of services in SNFs, AHCA proposes to eliminate all third-party billing for Part A services under Medicare and provide SNFs with an option to bill for all Part B services as well. The vast majority of abuses outlined by the General Accounting Office and the Inspector General involved over-charging and fraudulent billing for services provided under arrangement between outside providers and SNFs. AHCA's proposal will require point of service billing and that SNFs directly oversee the provision of services to our patients, verify the services were truly provided, and bill for these services directly. It is our responsibility to ensure billing in our facilities is accurate and honest and we intend to do so.

FRAUD AND ABUSE: POTENTIAL COST SAVINGS—Undetermined

In addition to developing proposals, such as consolidated billing, that discourage fraud and abuse in our industry, AHCA has been actively working to eliminate fraud and abuse from the health care industry in general. AHCA is a founding member of the Coalition of Health Associations United Against Fraud and Abuse, which consists of 17 health care associations which are working with Congress and the Administration to eliminate fraud and abuse. The Coalition has developed an anti-fraud and abuse proposal and is actively seeking its introduction in the House and Senate.

The proposal would:

- increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;
- provide adequate and thorough education for providers, consumers, and payers to prevent violations;
- protect Federal health care programs from unnecessary cost, utilization, and failure to deliver appropriate levels of care;
- be appropriate for the changing health care market; and
- separate willful from technical violations.

The Coalition's proposal will go a long way toward eliminating fraud and abuse from the health care industry by combining tough enforcement against those who intentionally violate the law, with education for those who seek to provide care within the complex rules of Medicare and Medicaid. I will submit under separate cover a summary of the proposal. I strongly recommend your Committee adopt this measure.

RESPIRATORY THERAPY: POTENTIAL COST SAVINGS—$1 Billion

One therapy service that is being provided in SNFs but is not reimbursed by Medicare directly is respiratory therapy. Abt Associates, Inc. will shortly release a study which estimates that the cost savings of utilizing SNFs rather than acute care settings in one DRG alone, #475 tracheostomy, one of the most costly DRGs, would save up to $990 million over five years. A 1993 CBO preliminary cost estimate predicted a $100 million revenue loss over five years due to a 10% increase in SNF service utilization. However, the estimate acknowledged that offsetting savings may be realized—*"if ventilator patients were moved from hospitals to SNFs, then fewer resources might be used in the treatment of these patients."* We strongly concur and there is ample proof in the marketplace that this is, in fact, taking place.

AHCA requests that your Committee reexamine this issue in view of recent data and increased utilization of SNFs for such care. Hospitals providing ventilator care charge upward of $1,000 per day for such care compared to approximately $350 per day charged by subacute SNFs. Costs billed by hospitals for such care are also driven higher when provided in SNFs under contractual arrangement because of administrative add-ons.

EQUALIZE COPAYMENTS: POTENTIAL COST SAVINGS—$28 Billion

Finally, in regard to home health care, we applaud efforts to move patients into the least restrictive and most cost-effective setting. However, due to the different acuity of nursing facility residents and patients that can be treated at home, we do not see home care as competing with nursing facilities, but rather as a complementary part of the health care continuum. For instance, average activities of daily liv-

ing (ADL) measurements for home health patients are 2.5 of 5 vs. 3.9 of 5 for SNF patients. We would support, however, that copayments be applied equally. SNFs residents are currently burdened with a copayment after 20 days of 1/8th of the annual hospital deductible amount. This is a steep $89.50 per day copayment that almost eliminates any benefit after the 20th day of a SNF stay. We would encourage your Committee to impose equal copayments for home care and SNF services and eliminate the unworkable current SNF copayment. This proposal would raise billions of dollars for deficit reduction, make consumers better buyers of services, and provide equal treatment for post-acute care providers.

THE PROOF IS IN THE PUDDING: JUST LOOK AT MANAGED CARE

As you examine ways to find cost savings, obviously you will closely scrutinize managed care. I highly recommend you examine how managed care is utilizing skilled nursing care to reduce hospital stays. Managed care has recognized the benefit of substituting SNF days for more expensive hospital days. In recent testimony before the Prospective Payment Commission, Dr. Roger Taylor, Executive Vice President with PacifiCare, one of the fastest growing managed care organizations in the nation, stated that a large percentage of their ability to save money was their ability to reduce hospital Medicare days per thousand through the utilization of SNF day substitution. In fact, if you will refer to the chart titled "Sicker and Quicker," you will see that PacifiCare has achieved a large part of its savings by reducing hospital stays from 1089 days per thousand members in 1990, to 964 in 1993, through correspondingly increasing their SNF days per thousand from 497 to 676.

Currently, 3.2 million Medicare recipients or 8.7% of all eligible beneficiaries are enrolled in managed care plans. Fully 76% of these beneficiaries are in risk contract plans and participation in these plans in 1994 increased by 16%. According to ProPAC, risk contract patients use hospitals less and length of stays are much shorter. Conversely, they utilize SNFs at a far greater rate. The reason: Substantial savings and quality. ProPAC confirms this on Page 72 of their recent report where they write:

> "Beneficiaries in risk contracting HMOs were just as likely to use hospital, physician, and home health services as their fee-for-service counterparts, but they used fewer of them, according to the program's 1992 evaluation. This was not true, however, for nursing home use. HMO enrollees were likelier to use a skilled nursing facility, although the length of stay was similar to that of FFS beneficiaries. *Apparently, plans were not limiting access to ambulatory and inpatient services, but were using skilled nursing facilities in place of some hospital days.*"

AHCA supports the utilization of managed care to provide quality care and control costs. In particular, we commend the Congress for extending and expanding the Medicare Select Demonstration Project and for exploring ways to increase Medicare beneficiaries in managed care risk contracting. We believe the move by Congress to reexamine the entire Medicare program and its relationship to private sector efforts in managed care are welcome and will be fruitful.

In Orange County, California, where over 50% of Medicare eligible residents are enrolled in managed care risk contracts, artificial barriers that drive up costs—such as the 3-day stay rule—are avoided, and consumers are pleased with their coverage and care. The ability of managed care organizations to achieve cost savings by utilizing SNFs is something the Congress must examine. Follow the lead of the private sector and market-based reforms, and I believe you will find it easier to control Medicare costs.

LONG TERM CARE INSURANCE: A KEY TO FINANCIAL SOLVENCY

Let me conclude my remarks on cost containment by endorsing and supporting efforts by the Congress to improve long term care insurance by clarifying income tax rules and providing basic policy standards. Probably the best long-term way to reduce government costs is to build on the private side of the existing public/private partnership for long term care by encouraging more senior citizens to purchase long term care insurance policies early on. A 1994 study by Cohen, Kumar and Wallack found for that each long term care policy held by someone entering a nursing home, Medicaid saves between $8,000 and $15,000.

Perhaps most importantly, the tax clarifications passed by the House and awaiting your approval are a critical factor in slowing the growth in Medicaid spending on long term care. In fact, it should be our mutual goal of phasing-out, privatizing, or vouchering the Medicaid long term care program into a private insurance program. This Committee must look at new alternatives that go beyond simply block

granting the program and moving the problems of long term care financing to the States. Private, long term care insurance is the key.

POST-ACUTE CARE BUNDLING: ANTI-FREE MARKET, ANTI-QUALITY

One recommendation that was suggested as an option by the House Budget Committee is bundling all post-acute care services into the hospital DRG system. This is an extremely flawed and unreasonable proposal which would not obtain the cost savings estimated by the Congressional Budget Office.

- Post-Acute care was designed to reduce higher acute hospital costs. The bundling proposal would shift services back to higher cost centers.
- SNFs and home care are cost effective alternatives to hospitals. This proposal flies in the face of the hospital PPS system
- SNFs and home care offer free-market options for consumers. This proposal eliminates competition for services by bringing all services under hospital control
- HCFA is years away from having the data to implement such a system. HCFA is perhaps three years away from a SNF PPS and 18 months behind that on home health
- Hospitals are ill-prepared and do not have the immediate service capacity to offer cost effective post acute services.
- This is an antiquated proposal that has found little support. Studies show serious design and accountability problems with such a system. A bundling system of this type is unworkable.

Bundling in theory may sound like it makes sense. In fact, as proposed in the House, it would strike at the heart of free-market competition, access to care, and most importantly, quality of care. Hospitals would attempt to dump costly outlier patients on SNF, rehab and Home Health providers that would have to refuse to take these patients they could not possibly afford to take with a DRG add-on. Much less one reduced by whatever the hospital determines to be a reasonable mark-up or administrative charge.

RELATED MEDICARE RECOMMENDATIONS

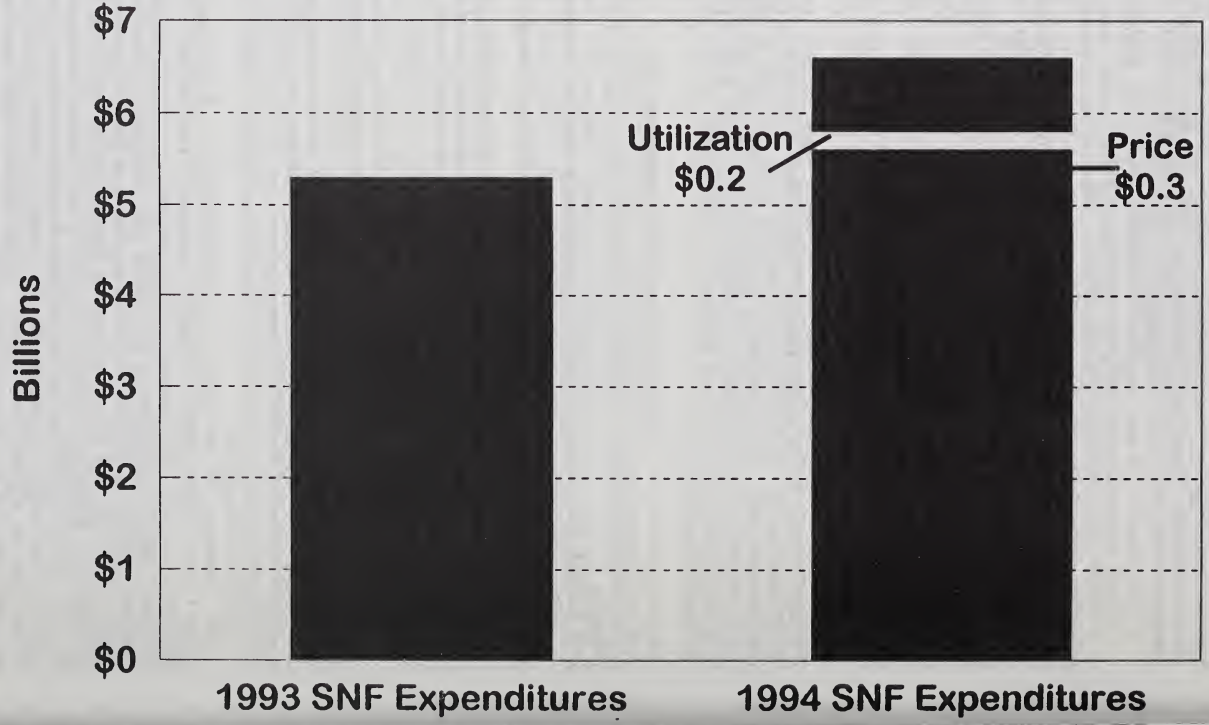
Let me briefly make a few final recommendations to the Committee before wrapping up.

- Extend the waiver of liability provisions protecting innocent providers who make unintentional paperwork mistakes
- Allow providers to make reasonable and customary charges for services rendered under the related party rules
- Oppose HCFA attempts to "fully certify" Medicaid and Medicare beds in nursing facilities. This proposed policy could lead to upcoding and over-utilization due to the huge number of new Medicare beds that would be made available for services. The potential cost of this proposed rule should be examined closely by this Committee
- Carefully monitor the implementation of the 1995 Survey, Certification and Enforcement rules to ensure they are cost-effective, are not abused by over-zealous inspectors, and are enforced fairly and evenly
- Adopt ProPAC's recommendation on Page 49 of this year's report to Congress to examine "paying hospitals that transfer patients to non-PPS settings a per diem instead of the full DRG amount"
- Support previous agency and Congressional efforts to place a moratorium on long term hospitals.

Mr. Chairman, let me leave this Committee with a final thought. I have come today to testify and offer you specific proposals to save billions of dollars from the Medicare program. Our nursing facility providers are already operating as probably the most efficient providers in the health care continuum. Their last Medicare update was based on 1990 costs, while according to ProPAC, last year "the overall profit margin for the nation's hospitals reached its highest point since the advent of Medicare's prospective payment system." For instance, our average profit margin in 1991 was only 3.2% compared to average hospital margins of 4.6%.

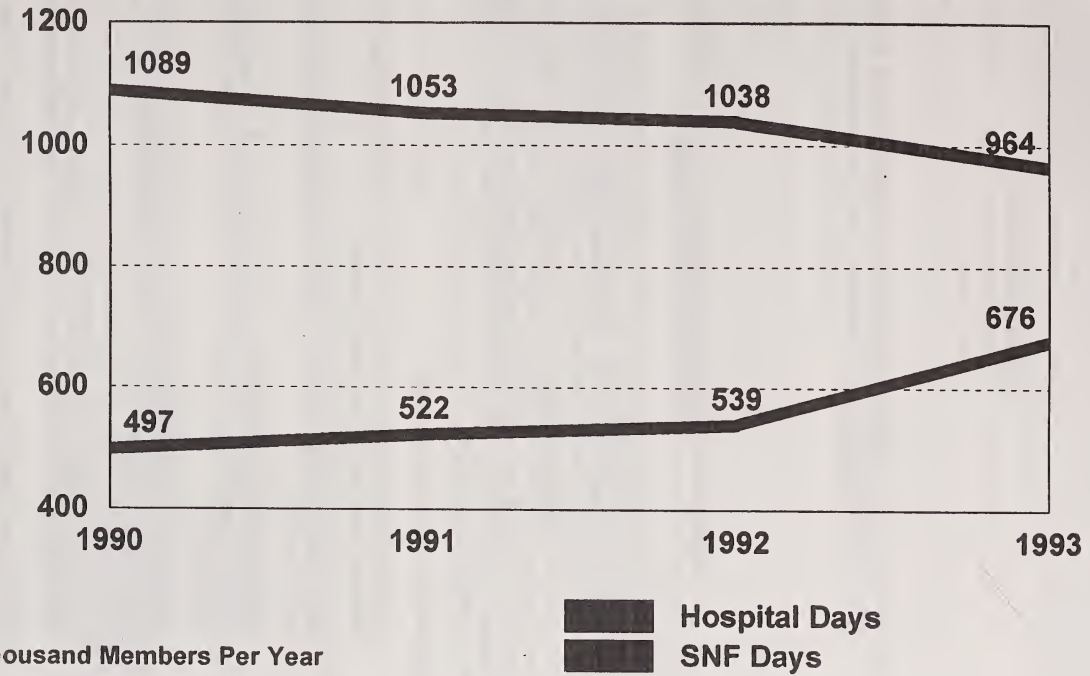
Your examination of nursing facility spending growth under Medicare is warranted and we applaud your efforts. We are, however, more a part of the solution, and not a part of the problem. We encourage you to review our cost containment proposals in time for budget reconciliation later this year, and to review SNF costs centers before determining any potential action. Most of all, we ask you to ensure that a prospective payment system for SNFs be required in statute in time for fiscal year 1998.

Population Pushes Up Costs



Quicker and Sicker

Utilization Trends 1990 - 1993 *



* Per Thousand Members Per Year
Data from PacifiCare of California

COMMUNICATIONS

STATEMENT OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

(SUBMITTED BY ANN B. HOWARD, EXECUTIVE DIRECTOR)

BUNDLING OF MEDICARE PAYMENTS IS ANTICOMPETITIVE AND DENIES PATIENT CHOICE

Senate and House Budget Committee documents propose bundling post-acute care services, including up to 60 days of home health care as well as all post-hospital SNF and rehabilitation services, onto the hospital DRG payment. Such a change in Medicare benefit and payment policy would make hospitals responsible for these services, supposedly correct the incentive hospitals currently have for discharging patients early to other settings, and save significant sums of money for the Medicare program. AFHHA has serious doubts about the validity of many of the assumptions underlying the bundling proposal. In addition, we are concerned about the negative consequences for Medicare patients and the freestanding home health industry that would result from adoption of such a scheme.

Among our concerns are the following:

- Medicare DRGs, designed for inpatient hospital care reimbursement, are not an accurate indicator of the need for post-hospital services.
- Only a small percentage of Medicare hospital DRG admissions are associated with post-hospital services.
- Many hospitals, especially rural facilities, will not be able or willing to assume the financial responsibility of arranging for post-hospital service, especially for an indefinite period of time.
- Contrary to Congressional budget committee claims, bundling will not lead hospitals to retain patients longer, but rather will extend current incentives for limiting inpatient care to post-hospital services.
- The bundling proposal is monopolistic and anti-competitive, and would have the effect of enfranchising hospital systems as the sole deliverers of post-hospital services.
- Bundling is anti-small business, and would lead to the destruction of a large percentage of the post-hospital infrastructure that currently provides home health, SNF, and rehab services in the community.
- Bundling is anti-patient freedom-of-choice, locking beneficiaries into the providers and modalities of care dictated by the discharging hospital.
- Bundling forces all Medicare beneficiaries who happen to be hospitalized into managed care whether or not they wish to be in a Medicare managed care system.

In addition, the savings projected by beneficiary copayments are little more than illusory when applied to a cost reimbursed benefit. In scoring a home health copayment, it would appear that the Congressional Budget Office (CBO) failed to take into account provider behavioral changes that inevitably will occur if a copayment is imposed on the current reimbursement system. These changes, which are totally predictable, would result in new expenses for the Medicare program in the form of reasonable costs incurred by home health agencies. Among these are:

- o hiring of new staff to perform the copayment billing and collection function;
- o purchase or lease of new equipment, software, and supplies to assist in performing the collection function; and
- o the interest cost of loans secured to allow the home care agency to continue operating while attempting to collect copayments from beneficiaries, third party payers, the Medicare program, and other Federal and state programs.

CBO scoring must also take into account the replacement value of home health care. Patients not receiving medically necessary services at home will end up utilizing more costly hospital and nursing home services at a greater cost to the American taxpayer.

In addition to imposing an enormous administrative burden, the cost of which will accrue to Medicare, copayments will represent small amounts and will cost more to collect than the amount of the copayments.

Truth in scoring demands that the above-mentioned factors be taken into consideration by Congress, CBO, and the Administration.

(B) Higher utilization of Medicare home health services is directly related to:

- o the number of medical conditions and diagnoses a patient has ever had;
- o patients who have three to five deficiencies in activities of daily living (ADL);
- o beneficiaries who live alone;
- o racial minority status;
- o low income, as indicated by Medicaid eligibility, which in turn is related to poorer health status and higher morbidity; and
- o the number of nursing beds in the community -- home health utilization is higher in communities with fewer nursing home beds.
  ("A Profile of Home Health Users in 1992," Mauser, Miller, Fall 1994, p. 17- p. 33).

II. According to a September 30, 1994, study (Patient, Agency, and Area Characteristics Associated with Regional Variation in the Use of Medicare Home Health Services) prepared by Mathematica Policy Research, Inc., a research firm which frequently contracts with HCFA: "Resolution of the 1988 Duggan v. Bowen lawsuit led HCFA to clarify home health regulations in mid-1989... (T)here is anecdotal evidence that a substantial number of agencies have not attempted to make use of these clarifications because they still operate under the specter of the high denial rates of the mid-1980s." (p. 8).

The foregoing would indicate that many home health agencies may still be self limiting the number of visits provided, out of fear of denials. If providers self limit and do not exercise Medicare appeals rights on behalf of beneficiaries or on their own behalf, the number of visits per patient may well be artificially low compared to areas where home care providers and physicians (1) have adopted practice patterns which encompass revised and more expansive HCFA coverage criteria, and (2) vigorously exercise their appeals rights.

The Mathematica report tends to confirm a number of Mauser's and Miller's conclusions, noted in I.(B) above, with respect to the factors which are found in conjunction with high home health utilization in some states and areas of the country. Among the correlations Mathematica found are the following:

- Home health beneficiaries in the South Central regions are "more likely than average to have primary diagnoses... of diabetes or hypertension and other cerebrovascular conditions,... were also much more likely to have a secondary diagnosis of incontinence... (I)ncontinent patients are more likely to develop dicubitus ulcers... that are difficult to heal and, if catheterized, are more likely to develop frequent urinary tract infections... (and) were... somewhat more likely than average to have a secondary diagnosis of malnutrition or dehydration, an indication of poor health status." (p. 34).

- The percentage of elderly living in poverty is highest in the South Central region, and "Low income is often associated with poor health and may increase the use of home health care." (p. 37).

- Racial minorities, a significant percentage of the population in most high utilization regions, are more likely to use home health services and to receive more visits than non-minority patients. (p. 34).

Mathematica also corroborates the link between the number of nursing home beds in a community and home health utilization, stating: "...(I)f nursing home beds are scarce, beneficiaries are more likely to use home health care (either while awaiting nursing home placement or instead of nursing home placement). Similarly, if hospitals have very high occupancy rates, they may be inclined to discharge patients sooner and with greater posthospital home health needs than otherwise." (p. 7).

Mathematica adds: "In addition, alternative providers (such as nursing homes) may be unwilling to serve a particular type of patient (for example, ventilator-dependent patients or patients with dementia) if they do not perceive themselves as adequately compensated for caring for that type of patient or if they do not have the specialized resources the patient needs. Care for some of these patients may then fall to home health agencies, if the patients also have skilled needs." (p. 7).

The American Federation of Home Health Agencies, a national association representing Medicare participating home health agencies, believes that Congress has a somewhat schizophrenic attitude towards the Medicare home health benefit. On one hand, Congress tells us that they understand why home care has grown and they are enthusiastic in support of the benefit... but at the same time there is a conflicting current that says, in effect, "home health is growing fast so we must shoot it."

CONGRESS SHOULD BE PRAISED FOR CREATING A SUCCESSFUL HOME HEALTH BENEFIT

Congress and the Clinton Administration have expressed concern about the recent growth of the Medicare home health benefit. Rather than regard this growth as a problem that must be attacked with imposition of bundling, beneficiary copayments or other artificial utilization controls, Congress should build on the great success of the home care benefit.

Hospital prospective payment (PPS), passed by Congress in 1982, has worked just as Congress intended it to work. It has resulted in the discharge of Medicare beneficiaries to the home and other outpatient settings more quickly and in a poorer state of health.

The growth of Medicare home care stems from a variety of factors, primarily:

1. Reimbursement changes, noted above, leading to the early discharge of Medicare patients from hospitals;

2. Technological advances which have given home health agencies the ability to provide all health services short of surgery in the home;

3. The aging of the American population, as well as an increase in the average age of home health recipients, which is now approximately 79 years of age;

4. Strong family and patient preference for cost-effective family-oriented home care services; and

5. A 1988 Federal court decision (Duggan v. Bowen) that reversed restrictive Federal policies which denied home health services to a number of otherwise eligible beneficiaries on the claim that they were in effect "too sick" for home care.

In addition to the overall growth of the home health benefit, per patient utilization of Medicare home health services has increased, from an average of 23 visits in 1980 to 53 in 1993. There are considerable state and regional variations in utilization patterns, as indicated by attachment #2.

No doubt there are home health agencies which have engaged in what could be considered "overutilization." Home health utilization must be appropriate; it is and should continue to be the duty of The Health Care Financing Administration (HCFA) and its intermediaries to ensure that the number and type of visits provided are appropriate.

Some in Congress and in the home health industry, however, may jump to the conclusion that "too many" visits are being provided in the high utilization states rather than perhaps "too few" visits are being provided in the states ranked near the bottom in utilization. We do not have a definitive explanation for the variation but we do have strong indications that there are legitimate reasons for the regional variations and that there is a correlation between utilization and outcomes.

I. Two articles in the Fall 1994 issue of the Health Care Financing Review, published by HCFA, indicate the following:

(A) Greater per patient utilization of home care may be associated with better patient outcomes, as indicated in a comparison of Medicare HMO patients with Medicare patients receiving services from fee-for-service home health agencies. Fee-for-service agencies provided significantly more visits and demonstrated significantly superior outcomes for beneficiaries. ("Home Health Care Outcomes Under Capitated and Fee-for-service Payment," Shaughnessy, Schlenker, Hittle, p. 187-p. 221);

In recent years Congress has twice indicated its desire to move the home health benefit off of the current antiquated reimbursement system. In 1987, it mandated a PPS demonstration which is still in progress and just now entering its second phase. In 1990, Congress directed HCFA to develop an alternative reimbursement approach for the home health benefit by October 1993. Although HCFA failed to meet this deadline, it has recently promised Congress a proposal by 1997. AFHHA believes we cannot afford to wait until 1997.

We have expended considerable time and resources in conducting expert actuarial analyses of HCFA's home health care cost data and formulating a legislative proposal that replaces the cost-based system with PPS. This proposal was incorporated into the Penny-Kasich and Kerrey-Brown deficit reduction amendments in 1993. It was also a part of two subsequent Republican budget resolutions. AFHHA believes the proposal has as much merit today as it did in 1993; indeed, the factors commending its adoption are far stronger today than they were in 1993.

The proposal would replace the current retrospective cost-based reimbursement methodology with a standard payment rate, prospectively determined, for each visit for each type of service. This PPS model is designed to promote the cost-effective delivery of quality services to Medicare patients and to reduce unnecessary regulatory burdens on agencies such as fiscal intermediary micromanagement of agency business decisions and practices.

The standard payment rate system, like the hospital inpatient prospective payment system, would be more effective than the current cost-based system in controlling costs. Because payment is made for the actual costs of services (up to a limit) the current retrospective system is inherently devoid of incentives to minimize costs. The standard payment rate system, utilizing fixed payment amounts, would give providers incentives to maximize efficiency and minimize costs. The benefit to Medicare would be program savings.

Further, under the proposal many of the administrative burdens that are part of the cost-reporting system would be reduced. Providers would still be required to make reports to HCFA through the fiscal intermediaries, but the reporting would be simplified.

Under the proposal an individual's eligibility for home health services under Medicare and patients' access to services would not be changed in any way. Neither would the proposal affect quality of care or utilization of the benefit.

Specifically, the proposal would:

* establish the base per visit rate for each type of visit at 93 percent of the mean of the labor-related and nonlabor costs of that type of visit, adjusted by the area wage index;

* update the per visit payment rates annually based on the home health marketbasket increase;

* as under present law, provide for an add-on for certain non-routine medical supplies identifiable as services to an individual patient (other than medical equipment, orthotics, and prosthetics) associated with skilled nursing visits;

- Contrary to Congressional claims that bundling would take health care decisions out of the hands of government bureaucrats and turn such decisions over to health professionals, in reality bundling would have an opposite effect. It would take health care decisions out of the hands of physicians and other health care professionals and turn them over to hospital financial managers.

Many of the above points are the very arguments that Republicans used so successfully against President Clinton's health care reform bill last year. Republicans charged that the President's plan was anti-competitive and would deprive consumers of freedom of choice of provider. The same charges can be leveled against the post-hospital bundling proposal. It is significant that House Speaker Newt Gingrich has stated on a number of occasions that he opposes forcing Medicare beneficiaries into managed care against their will. Post-hospital bundling would not appear to be consistent with this position.

PPS FOR HOME HEALTH CAN BE ENACTED TODAY

AFHHA advocates the application of market-based principles to the Medicare home health benefit, as a means of reducing inefficiency, providing incentives for cost-effectiveness, and reducing the cost of the program for taxpayers. Specifically, we have proposed replacing the current retrospective cost-based reimbursement system -- a system inherently devoid of incentives to providers to reduce costs and increase efficiency -- with a prospective payment system (PPS). Home health is still one of the few services not reimbursed prospectively by Medicare. There is widespread agreement among experts that the prospective system used for hospitals has resulted in significant program savings over the last decade and that similar savings could be achieved in home health.

Home Care Is Cost-Effective Even For High-Utilization Beneficiaries

Home health care is cost effective even for the most frequent users of services -- those beneficiaries who receive more than 150 visits per year. According to Mauser and Miller, for this category of patients, the average number of visits received in 1992 was 250 and the average total reimbursement was $12,276.00. (p. 2).

We would contend that this is a great cost effective bargain for the American taxpayer. A patient requiring 250 visits a year is a very sick patient. If such a beneficiary is unable to get vital services in the home, he or she will end up in an institutional setting at a much greater cost to the Medicare program and the American taxpayer. Hospitals and skilled nursing facilities could not begin to provide substitute care at anywhere near the home health agency's level of cost effectiveness.

A COPAYMENT ON COST REIMBURSED MEDICARE HOME HEALTH SERVICES BURDENS BENEFICIARIES AND PRODUCES LITTLE BUT ILLUSORY SAVINGS

Imposition of a copayment on the Medicare home health benefit may at first glance appear to furnish an easy and fair source of revenue. Congress may look at other Medicare benefits like hospital and skilled nursing facility services, see a requirement for cost sharing that has saved the program money, and assume the same would be true if a copayment were applied to the home health benefit.

A copayment cannot be applied soundly in the context of a cost reimbursement system since all reasonable and allowable expenses incurred by a home health agency in the process of furnishing services to Medicare patients, including those associated with the copayment, are costs that accrue to the Medicare program.

A copayment imposed on the current Medicare home health reimbursement structure will have perverse unintended consequences. The most cost effective providers will be disproportionately disadvantaged. This will occur because copayments are likely to be based on average costs per visit, the model that has been incorporated into numerous deficit reduction and health care reform bills.

To illustrate the perverse impact, if the average skilled nursing visit cost is $80.00, a 20 percent copayment would be $16.00. This copayment amount would represent 27 percent of the per visit costs of an extremely efficient home health agency which provides a skilled nursing visit for $60.00, but only 16 percent for a high cost agency which provides a skilled nursing visit for $100.00. The lower an agency's cost, the greater the copayment burden. This situation will no doubt serve as an incentive for providers to allow their costs to move up to the cost limits.

* provide for the development by the Secretary of a system whereby an actuarially sound random sample (not more than 5 percent) of home health agencies is required to file full cost reports each year for the purpose of enabling Congress and HCFA to compare the actual costs of agencies with the standard payment rates;

* provide for the development by the Secretary through regulation of a simplified cost report for the same purpose stated above for the remaining 95 percent of home health agencies;

* provide for exceptions and adjustments to the payment rates (waiver) as the Secretary deems appropriate to take into account the special circumstances of only those home health agencies whose actual costs significantly exceed the standard payment rate amounts for reasons beyond the control of the agency.

While the government and the taxpayer realize genuine program savings, those HHAs who work to reduce their costs and promote efficiencies will be rewarded. Unlike the current system, the prospective payment system will foster efficiency by eliminating needless and time-consuming reporting and regulatory burdens. Even those agencies whose costs are above the payment rates -- and there will be some, just as there are already agencies with costs above the caps -- will be advantaged by being liberated from these burdens.

In addition to developing this proposal, AFHHA continues to work with other national and state home health associations, including through the "PPS Workgroup," on the development of a joint industry proposal that address Congress' concerns and ensures the benefit makes sense for beneficiaries, providers, and the Medicare Trust Fund.

Statement of the American Society of Internal Medicine

INTRODUCTION

The American Society of Internal Medicine represents physicians who specialize in internal medicine. Internal medicine is the largest medical specialty, and internists take care of more Medicare patients than any other specialty. Because of the crucial role that internists play in providing primary care and specialty care to elderly patents, changes in Medicare payment policies will have a direct—and disproportionate impact—on internists and their patients.

ASIM has a long history of support for reforms to improve the predictability, rationality, and cost-effectiveness of Medicare payments. The society was the first to call for legislation to base Medicare payments on a resource based relative value scale (RBRVS), and was a key proponent of the Medicare reforms enacted in 1989. One of the principal objectives of Congress in enacting the 1989 reforms was to create incentives for primary care.

On January, 1996, the transition to resource based Medicare payments will be completed. Although the RBRVS has redistributed payments from surgical procedures towards primary care and other evaluation and management services, such as hospital visits and consultations, the Medicare fee schedule has fallen far short of producing the incentives for primary care that Congress intended. Certain policies that were adopted in 1989 or in subsequent years have undermined the benefits from the RBRVS. Those policies include differential conversion factors and volume performance standards (VPSs), budget-driven changes in the VPSs that were enacted by the 103rd Congress, and flaws in HCFA's implementation of the fee schedule.

ASIM believes that Congress must act now to correct the flaws in the Medicare fee schedule. This statement will review some of the problems with the current fee schedule, the legislative and regulatory history that has produced those flawed policies, and ASIM's recommendations for improvement.

ASIM also supports immediate and long-term reforms in the Medicare program to keep it affordable for taxpayers and beneficiaries that go beyond the recommended improvements in the Medicare fee schedule. Copies of ASIM's proposals have previously been sent to the members of the Finance Committee under separate cover. ASIM would welcome the opportunity to testify on its entire package of proposals for improving Medicare, which include recommendations for changes in the financing of the current program; improvements in the Medicare risk contracting

program; and enactment of a defined federal contribution—or voucher system—that could be offered on a voluntary basis to beneficiaries.

REFORMING THE MEDICARE FEE SCHEDULE

ASIM believes that any attempt to reform Medicare that does not address existing inequities in the Medicare fee schedule that distort the intent of the resource based relative value scale—and that also create strong financial disincentives for physicians to enter and remain in primary care—will only lead to further imbalance within the system. These inequities stem from a number of decisions made by past Congresses in enacting and modifying the original 1989 Medicare physician payment reform plan.

Under Medicare law, there are three separate target rates of spending growth—called volume performance standards (VPS)—for surgical procedures, primary care services, and all other nonsurgical services. This has resulted in three separate conversion factors—the dollar multiplier which translates Medicare's resource based relative value scale (RBRVS) into fees—for surgical procedures, primary care services, and other nonsurgery. Prior to 1993, there were only two separate VPSs and conversion factors, one for surgical procedures and one for nonsurgery.

In OBRA 93, Congress added a VPS category for primary care services—office, nursing home, home, and emergency room visits—in addition to the other two categories. Creation of a separate primary care category was intended to moderate any adverse impact on primary care services of other changes made by OBRA 93 lowering payments for physician services. However, all services paid under the Medicare fee schedule—including primary care services—will begin experiencing payment reductions in the next two years and beyond because OBRA 93 doubled from two to four percent the required "performance standard reduction" that is subtracted from the five year historical rate of increase for physician services for the purposes of calculating the VPSs.

It should be noted that in 1993 the Finance Committee's reconciliation package included a separate primary care volume performance standard with a zero performance standard reduction for this category of services only. Had the Finance Committee proposal been accepted in conference, it would have mitigated some or all of the payment reductions for primary care services that will occur beginning in 1996. ASIM supported the 1993 Finance Committee proposal. Unfortunately, the House-Senate conferees accepted a separate primary care VPS and conversion factor, but with the same four percentage points performance standard reduction that is applied to the other categories of services. As a result, the separate primary care VPS has not helped primary care in the way intended by the Finance Committee in 1993.

ASIM's concern about the impact of Medicare cuts is exacerbated by the fact that the current formula for determining Medicare fee schedule updates, as modified by OBRA 93, will have a greater adverse impact on primary care and other nonsurgical services than on surgical procedures. These are the facts:

- Under current law, the amount that Medicare pays for primary care services will automatically be cut by 2.2 percent in 1996, unless Congress decides otherwise. Primary care is the only category of Medicare expenditures that will be cut next year even before additional savings are mandated.
- Under current law, all other physician services are expected to join primary care in experiencing annual fee cuts beginning in 1997 and continuing every year, according to the CBO and Physician Payment Review Commission. Medicare payments for primary care will be cut by 17 percent over the next seven years.
- Additional proposed savings, such as the three percent reduction in updates proposed by the House Budget Committee's Health Care Working Group, will cut Medicare fees for primary care services by more than 31 percent over the next seven years, even without considering the impact of inflation. Other proposals would cut fees even more.
- Under previously enacted and proposed cuts, Medicare fees nationwide for a typical 15 minute office visit will drop from about $35.00 in 1995 to $34.00 in 1996, $27.00 in the year 2000, and less than $24.00 in 2002.
- Because of the cuts, Medicare fees for primary care services will not cover overhead. According to national surveys, internists in 1992 incurred annual overhead costs of $172,900, or $3458 weekly (assuming 50 work weeks). Internists' offices are open an average of 27.3 hours per week. This means that the overhead costs are $126 per hour for each hour the office is open. In 1996, internists will barely break even under Medicare's fees for a 15 minute office visit ($136 in revenue per hour). By 2000, the revenue from office visits—$108 per hour—

would not cover overhead even assuming no increase in overhead costs from the 1992 costs.

- Many internists report that they will have no choice but to limit the number of Medicare patients in their practices, to curtail services, or to take other steps to reduce reliance on Medicare if the current and proposed cuts are allowed to go into effect. A recent ASIM survey of a typical group of several hundred internists nationwide asked how they would respond to reductions of "up to 20 percent" in Medicare fees. Since the proposed reductions would be much greater, their responses underestimate the probable adverse impact on patient care. Only 25 percent said they would "make no change" in their practice. Forty-six percent would limit the number of new Medicare patients; 8 percent would discontinue taking care of current Medicare patients; 10 percent said they would change their career; 31 percent would change their practices so that they are no longer dependent on Medicare revenues; 38 percent would reduce services to beneficiaries; and 21 percent would plan an earlier retirement.

The following chart illustrates what will happen to payments for three different types of primary care services under cuts already contained in the law and under proposed reductions. The "current law" column reflects established 1995 fees, the 1996 default update of −2.2 percent for primary care services, and the PPRC's estimates of the conversion factor reductions for 1997-2002 based on savings mandated by OBRA 93.

The "proposed 3 percent reduction" column assumes that Congress allows the −2.2 percent default update for primary care services to go into effect in 1996 and reduces the conversion factors for all services by 3 percent per year beginning in 1997. These figures assume a reduction in future updates of 3 percent per year as proposed by a subgroup of the House Budget Committee and do not include other proposals in the subgroup's document that would save another $16 billion in physician services paid under the Medicare fee schedule. Although the Senate Budget Committee did not identify specific reductions in Medicare fee schedule payments to achieve its proposed Medicare savings as the House Working Group did, the charts illustrated what will likely occur under current law and what the impact would be if Congress decided to enact a three percent reduction in all future annual updates. Even if Congress does not enact the 3 percent conversion factor update reduction, other savings proposals that would result in a comparable reduction in Medicare fee schedule payments would have the same impact as illustrated below.

Because the estimates in both columns do not take into account the impact of inflation, they understate the extent of the reductions in payments for primary care services.

Office Visit (level 3)

	1995	1996	2000	2002	Percent Change
Current Law	$34.92	$34.16	$30.50	$28.93	−17.2
3% CF Reduction	$34.92	$34.16	$26.90	$23.97	−31.4

Nursing Home Visit (level 2)

	1995	1996	2000	2002	Percent Change
Current Law	$48.39	$47.32	$42.25	$40.09	−17.2
3% CF Reduction	$48.39	$47.32	$37.27	$33.21	−31.4

Home Visit (level 2)

	1995	1996	2000	2002	Percent Change
Current Law	$61.48	$60.13	$53.69	$50.94	−17.1
3% CF Reduction	$61.48	$60.13	$47.35	$42.20	−31.4

To correct the flaws that will otherwise worsen the impact on primary care and other nonsurgical services, ASIM strongly supports the following recommendations in the Physician Payment Review Commission's 1995 Report to Congress:

A single volume performance standard and update for all categories of services should be adopted. If separate standards and updates by categories of serv-

ices are retained, they should be based on the recent trend in volume and intensity growth for each category as called for by the Omnibus Reconciliation Act of 1990, and differential updates should be in effect for one year only.

The current formula—five year historical trends minus a four percent performance standard reduction—should be replaced by per capita GDP, plus an additional factor of one or two percent.

There are several reasons why these changes in the law should be enacted:

First, mandating that the VPSs be based on GDP plus two percentage points is needed to reduce the adverse impact on access and quality that will otherwise occur from fee reductions. Because OBRA 93 doubled the performance standard reduction factor, it will be impossible to keep spending within the VPS targets. The PPRC notes that "the problem is that this [four percent performance standard] reduction is now permanently embedded within the default formula and applies even as the 1991 to 1993 growth rate is the lowest two-year growth rate since 1985. In effect, the formula demands that however well physicians did in meeting the previous year's standard, they must reduce volume by an additional 4 percentage points each year or pay a penalty in reduced fees. Clearly, it is impractical to expect that physicians will continue to achieve such savings year after year." The current formula sets in motion a steady decline in Medicare fees beginning in 1996 for primary care services, and in 1997 for all other services, that will continue into the foreseeable future. Because overhead costs cannot be reduced to offset these cuts, ASIM estimates that net Medicare payments will be reduced over 60 percent. The result will be a serious reduction in access to physician services and especially, access to primary care. Additional savings that Congress may mandate could have devastating consequences for access. A formula of GDP plus two would reduce or eliminate the fee reductions and the need to constantly reduce the number of services provided to patients. To maintain budget neutrality, a change to the GDP plus two formula could be offset by a one time reduction in the conversion factors, provided that this is done in a way that reduces the gap between the surgical conversion factor and the other two categories.

Second, the current method for determining the fee updates and VPSs will magnify and accelerate the access problems resulting from budget cuts. The elderly depend on primary care physicians for their access into the Medicare system. Primary care is therefore the first place where access problems will begin to become evident. As noted earlier, access barriers continue to exist for the very old, the disabled and the poor. The Physician Payment Review Commission staff estimates that under the current formula, the 1997 conversion factor for surgical procedures will be 26.7 percent higher than for primary care services and 29 percent higher than for other nonsurgical services. Because the conversion factors for primary care and other nonsurgical services start out so much lower than for surgical procedures, any additional cuts in the conversion factors will disproportionately hurt primary care physicians and other medical specialists. It is irrational to have in place a policy that is inherently disadvantageous to primary care when access to primary care is at the greatest risk of being reduced.

Third, the method for determining the VPSs and fee updates is inherently contradictory to the intent of the resource based relative value scale (RBRVS). The RBRVS was intended to pay physicians the same amount for services that involve equal physician work. But the current policy of different conversion factors will result in surgeons being paid 25-30 percent more for their surgical procedures than primary care physicians are paid for a non-surgical service requiring the same amount of time, mental effort and judgment, technical skill and stress. It is precisely the kind of contradictory federal policy exemplified by the VPS method that has led to widespread distrust and dissatisfaction with way that Washington does things.

Fourth, the current method encourages inefficiency, since it penalizes many physicians for changes in practice patterns that may reduce Medicare expenditures while rewarding others for reductions in volume over which they have no direct control. Some have argued that the policy of maintaining separate VPSs and conversion factors should be supported because it "rewards" surgeons for reducing volume by more than other physicians. The evidence suggests, however, that the reduction in surgical volume is due principally to changes in practice patterns, such as the substitution of less expensive forms of treatment by internists for conditions that used to require surgical intervention and a predictable reduction in the need for certain surgical procedures.

One of the objectives of physician payment reform was to encourage physicians to reduce the need for high cost surgical treatments by increasing pay-

ments for evaluation and management services, such as visits and consultations, and by encouraging the substitution of less costly treatments for more expensive ones. The shift in practice patterns to less invasive outpatient treatments that has occurred over the past several years is dramatically lowering the demand for surgical procedures. Unfortunately, when non-surgeons find ways to treat patients that avoid the need for surgery, they are penalized under the current VPS and update methods for providing more services, even though those services allow patients to be treated more efficiently by reducing the need for surgery.

Fifth, the current method is overly complicated. A single VPS and conversion factor would greatly simplify the method of determining Medicare payments. Currently, HHS must calculate three separate VPSs, monitor expenditure trends in each category, and determine three separate dollar multipliers, which are then transmitted to each Medicare carrier for use in calculating what is in essence three different fee schedules, depending on the type of service being billed. By contrast, under a single conversion factor, all resource based relative values would be multiplied by the same dollar multiplier, thus simplifying the Medicare fee schedule.

ASIM also believes that Congress should mandate transition to a single conversion factor and volume performance standard beginning in 1996. Congress should act this year to prevent the 1996 default updates—which will increase the existing distortions in the Medicare fee schedule—from going into effect. The PPRC has proposed that the 1996 default updates be replaced by a 1.1% update for all services. This recommendation would, however, lock in the existing inequities for at least another calendar year and unnecessarily delay transition to a single conversion factor. As an alternative to both the default updates and a 1.1% "all services" update, ASIM supports enactment of legislation that would establish 1996 updates that are consistent with achieving a single conversion factor as expeditiously as possible. The chart attached to this statement provides preliminary estimates of what the 1996 updates would be for each category of service under current law (default update), the PPRC's recommendation, and under a mandate that a single conversion factor be implemented in 1996. (It is ASIM's understanding that HCFA's Office of the Actuary will be calculating the impact of various transition options in the near future. The attached chart is based on the best information currently available to ASIM.)

Conclusion

ASIM urges the Finance Committee to report legislation that will eliminate separate conversion factors and volume performance standards, to bring about transition to a single CF as quickly as possible, to begin the transition in 1996 by adjusting the updates for each category of services so that they are consistent with the objective of basing payments on a single conversion factor, and to replace the current four percent "performance standard reduction factor" from historical volume and intensity growth with per capita GDP plus two percentage points. These improvements will bring the Medicare fee schedule much closer to Congress' original intent of creating incentives for primary care and basing Medicare payments on a rational comparison of the physician work involved in each service. ASIM looks forward to working with the committee as it considers needed improvements in the Medicare fee schedule.

ALTERNATIVE UPDATES AND CONVERSION FACTORS FOR THE MEDICARE FEE SCHEDULE IN 1996

CURRENT

	SURGERY	PRIMARY CARE	OTHER NON-SURGERY
Current 1995 Conversion Factors	$39.45 (vs. primary care: +8.4%, vs. other non-surgery: +14.0%).	$36.38	$34.62

DEFAULT

	SURGERY	PRIMARY CARE	OTHER NON-SURGERY
1996 Default Updates	3.9%	−2.2%	.6%
1996 Conversion Factors Under the Default Updates.	$40.99 (vs. primary care: +15.2%, vs. other non-surgery: +17.7%).	$35.58	$34.83

PPRC/HHS

	SURGERY	PRIMARY CARE	OTHER NON-SURGERY
PPRC/HHS Recommended Updates.	1.1%	1.1%	1.1%
1996 Conversion Factors Under PPRC/HHS Recommendations.	$39.88 (vs. primary care: +8.4%, vs. other non-surgery: +14.0%).	$36.78	$35.00

SINGLE CONVERSION FACTOR IN 1996

	SURGERY	PRIMARY CARE	OTHER NON-SURGERY
Budget neutral updates that would result in a single conversion factor in 1996.	−6.1%	1.8%	7.0%
Budget neutral single conversion factor in 1996.	$37.03	$37.03	$37.03

Statement of the National Alliance for Infusion Therapy

The National Alliance for Infusion Therapy (NAIT) submits this testimony to the Senate Finance Committee for the record of the hearing held by the Committee on July 26 regarding ways to improve the Medicare program and ensure its financial stability.

NAIT is a national association of providers and manufacturers who serve patients in need of home infusion therapy and other home care services. Home infusion therapy is life-sustaining treatment for people suffering from a variety of diseases and conditions, including cancer, AIDS, infections, severe pain, gastrointestinal disorders, and many others. Appropriately administered, it is far less expensive than comparable care in an inpatient setting.

We are pleased to discuss Medicare savings and reform proposals as they pertain to home infusion therapy. We believe that the Medicare system must be reformed to reflect more accurately the way health care is delivered today. We further believe that Medicare's management of home infusion therapy is an ideal example of how Medicare has fallen far behind the private sector, to the detriment of its beneficiaries.

There are few areas that are more illogical and self-defeating than Medicare's policies toward infusion therapy. Medicare defines home infusion therapy wrongly, and as a result, cannot cover it in a sensible manner or ensure that its beneficiaries are receiving quality care. We would be thankful if, as a result of this legislative process, Medicare is reformed so that home infusion therapy is defined properly. If that occurs, the program can ensure wise expenditures for home infusion therapy and quality care for its beneficiaries.

To better understand why Medicare's coverage and payment policies for infusion therapy do not work, it would be helpful to explain briefly what infusion therapy is and how it can be dramatically cost effective when properly provided.

Drugs are administered by infusion when other routes of administration are not possible, effective, or desirable, or when a sufficiently rapid therapeutic response is not likely to be achieved. In the case of parenteral and enteral nutrition, nutrient solutions are administered by infusion when the patient cannot ingest enough nutrients orally to maintain adequate weight and strength.

Infusion therapy has been provided in acute inpatient settings for several decades. The first infusion therapies introduced into the home setting during the 1970s were nutritional therapies -- parenteral and enteral nutrition. In the mid-1980s, antibiotic therapy, chemotherapy, pain management, and other therapies were added to the spectrum of infusion therapies that are commonly provided to patients in their homes. Currently, there are over 20 different therapies being offered in the home and other outpatient settings, and Attachment A provides a summary of the most common therapies and the clinical indications for their use. Medicare provides limited coverage of infusion therapy, and the portion of Medicare costs attributable to home infusion therapy is actually small in relation to total home care expenditures and extremely small in relation to the total program, but we still believe that it is an area that warrants serious change.

The use of home infusion therapy grew rapidly in the mid-1980s with the trend to release patients from the hospital at earlier stages of recovery to complete treatment in the home or other outpatient settings. In response to this trend, a new type of home care provider evolved, one that specialized in home infusion therapy and other high-tech home care services. These providers utilized technological developments and advancements in home nursing and pharmacy practice to create a "hospital without walls" concept of home care. Compared to inpatient care, home infusion therapy saves hundreds of dollars per day in hospital "room and board" costs, where patients are properly selected for home treatment. For home infusion therapy to be successful, however, nurses and pharmacists must collaborate with the patient's physician to

carry out a patient-specific plan of care. The activities of these professionals are described in Attachment B.

In many respects, home infusion therapy is a genuine success story, combining the application of clear incentives by the government with the technological advances of the private sector to offer high-tech care to persons in their homes. Medicare, however, does not see it that way. As far as Medicare is concerned, home infusion therapy does not really exist, at least not as the entire clinical community understands it. Rather, Medicare persists in looking at infusion not as the provision of therapy but as the delivery of products and equipment, without the accompaniment of medically necessary professional services. The Health Care Financing Administration (HCFA) has strenuously avoided all efforts to regulate home infusion therapy in a manner that would reflect accurately how it is provided. As a result, we believe that HCFA has missed opportunities to reasonably control expenditures for this benefit without reducing the quality of the care provided to Medicare beneficiaries.

Instead, HCFA has sought to control infusion therapy by grouping it with the delivery of products with which it has little in common. Parenteral and enteral nutrition (PEN) therapies are covered under the prosthetic device benefit of Medicare Part B, while other infusion therapies are covered at carrier discretion under the durable medical equipment benefit, also under Part B. Neither benefit explicitly recognizes the professional services described earlier. HCFA interprets both benefits as only covering drugs or nutrients, supplies, and equipment used in the provision of therapy. Although it is commonly understood, even within HCFA, that it is the nursing and pharmaceutical services that enable patients to receive care in the home at all, Medicare's coverage criteria still do not acknowledge that those services have any role in home infusion therapy.

A natural question arises at this point: What does HCFA gain by defining home infusion therapy simply as the delivery of products? The answer is simple -- short-sighted, short-term cost savings. If HCFA can cling to a product-only definition, then it can advocate for product-only reimbursement, even when it is clear that the products are only one component of therapy. HCFA can then trim the current payment so that not one dollar of reimbursement is applied to the provision of services. At best, this position is simply disingenuous, and at worst, it is dangerous for patients and constitutes a poor basis for the creation of new policies to guide the future.

This has resulted, year after year, in a tug of war between HCFA and home infusion therapy providers over HCFA's proposed cuts in reimbursement. HCFA's proposed cuts have varied over the years, but they would all accomplish the same thing, which is to halt any payment that may possibly reflect the provision of professional services. Each time, we have suggested alternative cuts that we believe make more sense and do not threaten patients, and Congress has generally responded well to our suggestions.

This year, HCFA is again suggesting harmful cuts in the form of competitive bidding. HCFA has been testifying before Congress that it wants the authority to competitively bid for certain services covered under Part B of the Medicare program, including parenteral and enteral nutrition. This is a seriously flawed proposal, and we believe Congress should reject it.

It is clear that HCFA and other advocates of Medicare competitive bidding are trying to convince Congress of its merits by touting the "competitive" nature of the proposal. Unfortunately, the Medicare competitive bidding proposal is nothing like the competitive bidding that occurs in the private sector every day. This is a very important point -- we do not oppose competitive bidding, as it is a way of life outside of the Medicare program. What is being proposed for Medicare, however, will do little more than drive many providers out of business and leave the market to the providers that do not provide good quality services along with the products they deliver. That, we hope you would agree, is not a good result for anyone, including HCFA.

In the private sector, health plans that use the competitive bidding approach to select providers rely on one or more of the following:

- quality standards developed by the health plan, or as an alternative, a requirement that all eligible providers be accredited by the Joint Commission on the Accreditation of Healthcare Organizations;

- a clear and accurate definition of the therapy(ies) in question, so that the providers will know precisely what is expected of them; and

- some means of measuring outcomes, so that the health plan can track the clinical effectiveness of the participating providers.

None of these mechanisms would be in place for the Medicare competitive bidding system. There are no program or quality standards for infusion therapy, because these are Part B therapies, and providers are not subject to Medicare conditions of participation. As noted above, HCFA persists in wrongly defining the very therapies it seeks competitive bids on, so that the winning bid will be limited to the items HCFA recognizes as covered under PEN therapy, and would exclude the professional services that make these therapies available in the home. Finally, there is no outcomes measurement mechanism at all in place for Medicare, so there is no way for the program to ascertain how its beneficiaries are faring under this new, untried system.

This all adds up, in our view, to a recipe for disaster for patients and providers alike. One can only imagine how poorly competitive bidding would work in other areas if the government purposely misdefines what is being bid on. For example, if the Department of Defense put out a bid for a new fighter jet, and explicitly excluded the cost of the engine from the bids it was seeking so as to appear to be "saving" money (at least on paper), the Congress and the public would be rightly indignant about the behavior of the Defense Department. HCFA's competitive bidding proposal warrants the same reaction, for the same reasons. We urge Congress to reject this ill-considered policy.

Recommendations

We understand the need to reform Medicare and find needed cost savings to ensure the solvency of the program. We believe there is a sensible way to achieve this for home infusion therapy without undermining quality and competition, as HCFA's competitive bidding proposal would do.

In short, our proposal is to redefine home infusion therapy under Medicare to include professional services. We are not seeking any reimbursement increase to reflect the more accurate definition. In fact, our proposal will allow HCFA to pay for professional services only when the patient needs them and thus save money. We have described the activities of nurses, pharmacists, and other professionals in caring for patients. However, this level of activity is not the same for every patient. Some patients actually may not need services from their home infusion therapy provider, either because they have access to services through another provider (nursing home, nursing agency) or because they have been on therapy for a long time and have grown proficient in self-administering their treatment. However, Medicare payment for home infusion therapy currently does not vary according to whether the patient is receiving services or not.

This is one of the main differences between Medicare and the private sector as far as coverage and reimbursement for home infusion therapy is concerned. Private insurers directly cover services, and pay for them according to the needs of the patient. Medicare pays the same for every patient, regardless of what the patient needs.

There are several ways to remedy this situation. We submit three options for your consideration:

I. One option is within the context of the broad Medicare reform measures under discussion, where beneficiaries would be given a choice among several alternatives for health care coverage, ranging from the current Medicare fee-for-service system to private sector options such as the use of vouchers and managed care. We would simply request that for all beneficiary options, there should be a standard definition of home infusion therapy that includes clinical services, drugs or nutrients, equipment, and supplies. We support the idea of moving Medicare beneficiaries out of the fee-for-service system into managed care. Even if that happens, however, some will choose to stay with the current system. For them, the definition of home infusion therapy should be the same as for those who choose a managed care option. This will ensure equity for beneficiaries who stay in the fee-for-service segment and will give Medicare the same ability as private-sector insurers to control reimbursement and utilization of home infusion therapy services.

II. If there is no broad-based reform of Medicare, there are still ways to improve the current fee-for-service system. A second option is to make a definitional change within the existing coverage of home infusion therapy. As stated earlier, home infusion therapy is covered under the prosthetic device and durable medical equipment benefits of Medicare Part B. Congress could leave infusion therapy within those coverage niches but expand the definition of the therapies to accurately reflect the clinical services in addition to drugs, nutrients, equipment, and supplies. This would allow the program to develop payment rates that reflect varying levels of service intensity.

III. A third option would be to remove coverage of home infusion therapy from the prosthetic device and durable medical equipment benefits and create a new coverage "niche" for infusion therapy that includes clinical services. Only those infusion therapies that are currently covered by Medicare would be covered, and, as in the second option, payment could be structured so that Medicare only pays for services when patients need them.

Any one of the three options described above, if properly implemented, would decrease total Medicare expenditures for home infusion therapy and bring Medicare in line with private-sector reimbursement of home infusion therapy. By simply acknowledging that the services are integral parts of infusion therapy, HCFA can determine when to pay for them and when not to pay for them and thus control cost in an intelligent manner.

In conclusion, we ask that Congress reject ill-conceived and anti-competitive proposals such as HCFA's competitive bidding system in favor of more progressive reforms. For home infusion therapy, this means recognizing the therapy for what it is: a service-driven, patient-specific approach to home care. In so doing, the Medicare program can realize savings without putting beneficiaries at risk and doing irreparable harm to the market. We appreciate the opportunity to submit testimony to the Committee, and we hope to work with Congress as it undertakes the task of reforming the Medicare program. If members of the Committee or their staff have any questions regarding this testimony, please contact Alan Parver or Jana Sansbury at (202) 347-0066.

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ATTACHMENT A
TYPES OF HOME INFUSION THERAPY

Introduction

Drugs are administered by infusion when other routes of administration are not possible, effective or desirable or when a sufficiently rapid therapeutic response is not likely to be achieved. In the case of parenteral or enteral nutrition, nutrient solutions are administered by infusion when the patient cannot ingest enough nutrients orally to maintain adequate weight and strength.

Clinically speaking, drug administration by infusion has advantages and disadvantages. When administered by infusion, the therapeutic agent is completely and reliably delivered to the bloodstream and is therefore immediately available to the body's tissues. In addition, large doses can be administered continuously, thus avoiding tissue damage from potentially irritating drugs. On the other hand, such administration carries with it the risk of systemic infection and venous irritation. Further, certain parenteral drugs can cause a negative reaction if they are incompatible with the patient or if they are administered too rapidly. In such cases, the consequences may be serious and even life-threatening. For these reasons, patients must be carefully screened for their suitability for home infusion therapy.

Typically, most home infusion therapy is administered intravenously (into a vein) but many other routes of administration are feasible, depending on the therapy and other clinical factors. Whatever route is chosen, any infusion requires two basic types of equipment: (1) a vascular access device (usually a catheter) through which the drug or solution enters the bloodstream and (2) an infusion device (usually a pump or a gravity drip system) to move the solution from its container into the delivery system and then into the patient. Technological advances in equipment over the last two decades have played a major role in making infusion therapy possible in the home, and future advances should continue to expand the range of treatment options in the home setting.

Clinical Indications for Home Infusion Therapy

Home infusion therapy is used to treat a variety of medical conditions. A few of the most common are listed below:

- **Infections** of many kinds, including osteomyelitis, cellulitis, endocarditis, respiratory infections, urinary tract infections, gynecologic infections, post-operative infection, cytomegalovirus infection, cystic fibrosis, chorioretinitis, pneumonia and Lyme disease. Such infections can be treated with IV administration of antibiotics.

- **Cancer**, including bronchial/lung, breast, prostate, colon, recto-sigmoid, kidney, ovarian and multiple myeloma. Cancer-related pain is often treated with home infusion therapy as well. Infusion therapy allows precise dosages of chemotherapeutic agents, which can be quite toxic if administered too rapidly.

- **Nutrition-related problems**, such as Crohn's Disease and enteritis, hypoglycemia/malnutrition following GI surgery, intestinal obstruction, short-bowel syndrome, smooth muscle disorders, esophageal cancer, infantile cerebral palsy, and stroke-related conditions such as dysphagia. These patients require IV administration or tube feeding of nutrient formulas.

- **AIDS-related conditions.** AIDS patients suffer from a variety of opportunistic infections and conditions associated with immune deficiency that can be treated with home infusion therapy. Cytomegalovirus infection, chorioretinitis,

pneumonia, anemia, malnutrition and severe pain are the most common. Thus, AIDS patients may receive several infusion therapies, including nutritional therapy.

- **High-risk pregnancy.** Home infusion therapy for these patients usually involves administration of tocolytic drugs such as terbutaline to prevent premature labor.

- **Congestive heart failure.** These patients benefit from IV administration of drugs such as dobutamine to help strengthen cardiac function.

- **Hemophilia.** Hemophiliacs need administration of agents that promote blood clotting (Factor VIII, Anti-Inhibitor Coagulant, Factor IX Complex).

- **Thalassemia.** This condition is caused by an excess of iron in the system and is treated through infusion of drugs such as deferoxamine.

- **Pituitary dwarfism and other growth disorders.** These patients require infusion of human growth hormone to assist in their growth and development.

Types of Home Infusion Therapy

Although a variety of infusion therapies are currently rendered in the home, the most common are antibiotic therapy, chemotherapy, pain management, parenteral nutrition and enteral nutrition. During an episode of illness, most home infusion therapy patients require periodic administration of a single drug or nutrient solution. However, some patients require multiple drugs or therapies concurrently. For example, cancer patients suffering from severe pain and malnutrition may need both pain management and parenteral nutrition; a patient with a serious infection from multiple organisms may need intravenous infusion of multiple antibiotics. Following is a description of the five major home infusion therapies.

Antibiotic Therapy. Administration of antibiotics to treat infections is the infusion therapy most commonly administered in the home. Some of the conditions treated with home antibiotic therapy are listed above. Treatment may last from as little as a few days to several months. Patients who are HIV positive and who have developed serious opportunistic infections often require treatment for significantly longer periods of time.

Chemotherapy. The parenteral administration of anti-neoplastic or anti-cancer drugs is intended to destroy or alter the growth pattern of malignant cancer cells. The type of drug, the frequency of administration and the duration of therapy depend on the type of cancer, the extent to which it has spread and the drug's action and toxicity. Some patients receive chemotherapy once a week for up to six weeks. Others receive it five to ten consecutive days each month. Still others are treated more frequently or for longer time periods. Because the potential dangers of intravenous chemotherapy include life-threatening toxicity, physicians, nurses and pharmacists must monitor chemotherapy patients closely.

Pain Management. Effective pain management using narcotics can alleviate severe pain, thereby decreasing anxiety and enhancing the quality of the patient's life. Chronic and severe pain may be caused by cancer, neurologic, orthopedic or certain AIDS-related conditions. Home pain management enables patients to leave the hospital and receive therapy in the comfort of their homes. It also enables terminally ill patients to spend the last weeks of their life in relative comfort in familiar surroundings with family and loved ones.

The frequency of administration and dosage depend on the medication and the patient's response to the medication. Because the severity of pain typically fluctuates over the course of a day, pumps that allow for continuous infusion of pain medication, as well as bolus "rescue" doses that the patient can self-administer up to a maximum dosage, are often used.

Parenteral Nutrition. Also referred to as intravenous hyperalimentation or total parenteral nutrition, parenteral nutrition enables patients to meet their daily needs for carbohydrates, proteins, vitamins, minerals, trace elements, fats and other nutrients through a surgically inserted venous catheter or other vascular access device. Parenteral nutrition is often recommended for patients with malnutrition resulting from Crohn's disease, short-bowel

syndrome, bowel obstruction, severe burns, malabsorption syndrome, pancreatitis, cancer, ulcerative colitis, and AIDS-related malnutrition. The common element of these indications is that the patient's digestive system does not permit the patient to absorb nutrients sufficient to maintain adequate weight and strength.

Parenteral nutrition formulas are designed to meet a patient's specific nutrient needs; the formulas specified in the physician's prescription are compounded by a pharmacist in a special environment designed to assure sterility. Clinical and laboratory tests are performed to monitor the patient's response to therapy. Parenteral nutrition may be administered continuously throughout the day or cycled over a prescribed number of hours each day (usually overnight). Since an accurate infusion rate is essential, an infusion pump equipped with alarms is used for administration.

Enteral Nutrition. Enteral nutrition involves tube feeding directly into the patient's stomach or intestine. Enteral nutrition therapy is appropriate for patients whose lower gastrointestinal tract functions normally but who are unable or unwilling to swallow, who have a gastric obstruction or who cannot otherwise ingest adequate amounts of food and fluids by mouth. Likely causes include surgery of the gastrointestinal tract, mechanical obstruction or malfunction caused by a malignant or non-malignant disease, a comatose state or Alzheimer's disease.

Most enteral nutrition patients are fed through a nasogastric or smaller feeding tube. The tube is inserted through the nasal passage with the proximal end placed into the patient's stomach or duodenum by a physician or nurse trained in such insertions. Often, enteral nutrition patients needing long-term therapy are fed through gastrostomy or jejunostomy tubes, which are inserted through a surgical incision in the abdominal wall, with the proximal end placed directly into the stomach or jejunum.

Enteral nutrition therapy formulas or solutions ordinarily are premixed by the manufacturer. They may consist of standard dietary ingredients or may be tailored to a patient's specific nutritional requirements. A relatively simple pump is often used to ensure accurate delivery of the formula.

ATTACHMENT B
DESCRIPTION OF PROFESSIONAL SERVICES

The process of admitting a patient to home infusion therapy begins with a telephone call from a physician, hospital discharge planner, home health agency, case manager, or payer. While office personnel or clinical staff can take referral information related to demographic data and insurance information, only a licensed pharmacist or registered nurse can receive orders for treatments and prescriptions.

A physician's treatment plan for the patient is developed; ideally, this should be a collaborative effort between the prescribing physician and the provider's pharmacist and nurse. The treatment plan is patient-specific, and sets forth the physician's therapeutic goals and desired regimen of care for the particular patient. The infusion therapy provider develops a plan of care to carry out the physician's treatment plan. Where patients require multiple therapies, the provider's plan of care can be quite complex and time-consuming to develop.

A clinical nurse specialist conducts an initial patient assessment to determine the patient's suitability for home infusion therapy. Normally, the nurse interviews the patient in person prior to discharge from the hospital, and visits the patient's home as well. The assessment includes an analysis of the home environment for safety and appropriateness for care delivery, a physical and psychosocial assessment, review of the patient's medical condition and current medication, vascular access assessment, and a summary of the patient's treatment prior to the home care admission.

The home infusion staff verifies insurance benefits, and contacts case managers if necessary to discuss service needs and payment. Often, a nurse and/or a pharmacist become involved in these discussions. Obviously, the absence of adequate insurance may cause the patient to decline home infusion therapy; likewise, a provider will be reluctant to accept an uninsured patient who requires costly treatment. However, inadequate or nonexistent insurance does not necessarily preclude a patient from eligibility for home infusion therapy.

Much of the savings from home infusion therapy are attributable to the fact that the patient or his/her caregiver are trained to administer the therapy. Nurses provide most of the patient training and education, although sometimes pharmacists participate. Training is often initiated while the patient is hospitalized, although it can be started after discharge. With some therapies, patients can learn the necessary procedures in one or two training sessions, totalling about 2-4 hours. On the other hand, a parenteral nutrition patient may require several sessions totalling up to 10-12 hours of training. Certain patients may have functional limitations, which diminish their ability to self-administer the therapy and to change equipment and drug delivery systems. The training regimen depends on the patient's response and ability to learn what is required.

Once the patient is trained and admitted into home treatment, the provider attempts to establish a schedule of deliveries, monitoring, and treatment. The preparation of drugs and solutions is performed by a pharmacist (or a trained technician working under the supervision of a pharmacist, if permitted under state law). Sterile admixture is performed under a laminar flow hood or in a Class 100 clean room. The pharmacist verifies the order received from the physician, and the pharmacist is responsible for checking the medical record for pertinent information before dispensing the prescribed medication. Information such as previous allergic reactions, laboratory tests, appropriateness of the treatment for the disease state, and potential drug interactions are evaluated prior to filling the prescription.

The patient is provided with the equipment required to administer the therapy, and a one-week allocation of supplies, including intravenous catheter supplies. Supplies and equipment vary depending on the therapy being provided.

The nurse initiates the prescribed therapy during the initial visit to the patient's home. The patient and/or caregiver subsequently begin to administer the therapy, and perform self-monitoring activities, at prescribed intervals. In the first week of therapy, a nurse may visit the patient daily to ensure that the therapy is being administered properly and to evaluate the patient's therapeutic response to treatment. In addition, the pharmacist and nurse are available 24 hours a day, 7 days a week to all home infusion patients to respond to problems or questions as they arise.

During visits, nurses perform on-going assessments and technical procedures as outlined in the plan of care. They assess the patient's condition, the vascular access device, the drug delivery system, the patient's compliance and response to therapy, their psycho-social adaptation to home care and their satisfaction with the services they have received. Additionally, they perform various procedures related to maintenance of the access device, conduct blood sampling, insert I.V. catheters, and provide further training to the patient and/or caregiver.

Even after the number of actual patient visits may decrease, a nurse and/or pharmacist communicates regularly with the patient regarding progress and problems. During visits and through other communications with the patient, information about the patient's clinical status, treatments provided and the patient's responses to treatment are recorded and communicated to other practitioners, providers, and the primary physician. This information, along with the results of laboratory tests, is reviewed with the physician during periodic reviews of the plan of care to determine if the goals of care are being met and whether the treatment regimen continues to be appropriate. Typically, it is during communications with the physician that changes in medication and treatment orders are received by the provider.

This routine continues until the treatment goals are met and the patient is discharged from service. Often, long-term patients become quite independent and adept at administering the therapy, thus lessening the need for a nurse to visit on a regular basis. These patients still communicate frequently, however, with the nurse and pharmacist by telephone.

Statement of the National Association for Home Care (NAHC)

The National Association for Home Care (NAHC) represents our nations's home care providers—including home health agencies, home care aide organizations and hospices—and the people they serve. NAHC is committed to assuring the availability of humane, cost-effective, high quality home health services to all individuals who require them. Toward this end, NAHC believes that America must do better at ensuring access to high quality home care and hospice services in both the acute and long-term care settings. These vital services provide millions of individuals—the aged, infirm, and disabled—the ability to receive care in the settings that allow them the highest level of satisfaction, independence, and dignity—in their homes.

As you know, home health represents a small, but growing part of the Medicare program. More enrollees than at any previous time are accessing in-home health services—about 9 percent in 1994 compared to 2 percent 20 years ago. There are many contributing factors to this growth. This statement will discuss specific legislative actions that have been proposed to reduce the rates of growth in the Medicare home health benefit, including proposals to enact home care copays and to bundle home care payments into the hospital DRGs. It will also set out NAHC's proposals for ensuring efficient, high quality home care.

Factors influencing recent and historical increases in the utilization of Medicare's home health benefit

The home health benefit has been a maturing program for most, perhaps all, of its existence in the Medicare program. In Medicare's earliest years of operation, home health expenditures amounted to only about 1 percent of the total. Therefore, although the benefit has increased at an average rate of 23.5 percent per year, it still represents a relatively small proportion of Medicare spending—only about 8.7 percent of the total estimated for 1995.

Congress has long considered home health care a cost-effective benefit and has taken steps over the years to encourage its utilization. For example, Congress eliminated the prior hospitalization requirement and the 100 visit limit, the home health deductibles, Part B copays and broadened participation to include nonlicensed proprietary agencies. These amendments removed barriers to needed home health care and recognized the advantages of home health services over other acute care settings from the standpoints of patient preference and cost-effectiveness.

The home health benefit became especially useful in meeting the needs of patients who were discharged from the hospital "quicker and sicker" as a result of the 1983 enactment of the Medicare hospital prospective payment legislation. The percent of all Medicare hospital patients discharged to home health care increased to 18 percent compared to only 9 percent in 1981. Technological advances have also done much to make the home a safe and effective acute care setting. These factors together with the aging of the population, the increased paperwork burden, and an increased public and professional awareness of home health care have all contributed to the home health benefit's rapid increases over the past 25 years.

The home health benefit increases that occurred in the 1989-1992 period were almost double the 23.5 percent average experienced over the life of the Medicare program.

Coverage clarification. In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be reimbursed. The result was a so-called "chilling effect" in which some Medicare-covered claims were diverted to Medicaid and regrettably some patients went without care. This "denial crisis" led in 1987 to a lawsuit (*Duggan* v. *Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit gave NAHC the opportunity to participate in a rewrite of the Medicare home health payment policies. Just as a lack of clarity and arbitrariness had depressed growth rates in the preceding years, NAHC believes the policy clarifications that resulted from the court case have allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25 percent) came in 1989 when the clarifications were announced; and an even larger increase took place (50 percent) in 1990, the first full year the new policies were in effect. However, growth in the number of visits is beginning to return to more modest levels. Data from the Health Care Financing Administration's (HCFA) Office of the Actuary indicates that the benefit has matured and that expenditure increases will fall to 7.8 percent by 1997.

Further, a recent report by the General Accounting Office, Budget Issues: Fiscal Year 1994 Budget Estimates and Actual Results, shows that Medicare home health care costs were well below projected levels of spending in 1994. Home care costs for 1994 were 12 percent, or $1.6 billion below estimated spending levels. Although HCFA assumed a slowdown in the growth in home health expenditures, the actual rate of increase slowed even more than anticipated, according to the GAO.

The National Association for Home Care urges Congress to take a close look at this report, coupled with data from the HCFA Office of the Actuary, which shows that the rate of increase in home care costs will continue to slow dramatically and level off to very modest levels by 1997.

Personnel shortage. Throughout much of the 1980s, the home care industry, along with the rest of health care, was suffering from a personnel shortage. Although there are still acute shortages of certain disciplines, it would appear that conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 8,100 in 1995.

New legislative requirements. In the past five years, the home health program has seen the addition of several costly legislative changes, including the OBRA87 home health aide training and competency testing requirements and the Clinical Laboratory Improvement Amendments of 1988. The costs associated with these changes are reflected in visit charges.

New administrative changes. The 1992 OSHA mandate regarding employee protection from transmission of HIV and Hepatitis B, including employee vaccinations, is a cost that must be borne by employers.

LEGISLATIVE PROPOSALS

NAHC is deeply concerned about proposals before this Committee both to enact home care copays and to bundle post-hospital home care costs into the hospital DRG

rates. We feel strongly that both these proposals would severely harm patient access to care, as well as the affordability and availability of care.

NAHC urges Congress instead, to consider implementing a fair and equitable per episode prospective payment system for home care. Such a system would put the onus for assuring appropriate utilization rates where it rightly belongs, on the providers' shoulders, and would put in place important incentives to ensure that care is provided in the most efficient, least costly manner.

NAHC Opposes Home Care Copays

NAHC vehemently opposes copayments on Medicare home health services. Home health copayments would create substantial financial burdens on Medicare beneficiaries. A 20 percent coinsurance would require the average Medicare home health beneficiary to pay over $900 in 1996. About 15 percent of the estimated 4.6 million home health recipients would incur copays of more than $3,500. Even a 10 percent coinsurance would require Medicare home health beneficiaries to pay average copays of over $480 in 1996. About 15 percent of these recipients would incur copays of more than $1,600.

A copayment will especially have an adverse impact on the elderly who are already health-care poor without this new expense. Seniors spend nearly twice as much of their income on their health care now as they did before Medicare began (10.6 percent in 1961 as compared to 17.1 percent in 1991). Most home health patients begin home care after a hospitalization. On average, these patients will have paid $1,700 or more in the preceding 12 months for Medicare premiums, deductibles and copays even before the first home health coinsurance comes due.

In addition, a home health coinsurance is regressive and falls most heavily on millions of the poorest and oldest Medicare beneficiaries. For example, individuals over age 75 account for less than half of the total Medicare population, but comprise nearly three-fourths of the home health beneficiaries.

Home health users also have fewer financial resources than the general Medicare population. About 12 percent of the elderly live below the federal poverty level, whereas nearly half of home health recipients are low income. Nearly three-fourths of the poor elderly do not own Medigap to help cover the costs of copays, and the Qualified Medicare Beneficiary (QMB) program, which is designed to help pay Medicare cost-sharing requirements for poor Medicare beneficiaries, does not provide adequate protection from these costs. Coinsurance for home health services, therefore, would fall most heavily on the oldest and poorest group of Medicare beneficiaries.

A coinsurance requirement for home health would also create strong barriers to care for those in need of home care. Home health was exempted from the Part B coinsurance in 1972 to encourage use of less costly, noninstitutional services. Reimposing coinsurance would dramatically undermine that effort.

Home health copayments are also inefficient and would add to the paperwork burden of home health providers. The collection of copayment amounts would create additional paperwork burdens. Many home health patients receive only a few visits (26 percent received fewer than 10 visits in 1992). Yet agencies would have to set up billing and tracking programs even for these relatively small amounts, increasing administrative costs.

Lastly, the Office of Technology Assessment (OTA) recently found that making patients responsible for copayments will keep them from seeking necessary care and could be especially harmful to those with low incomes.

NAHC Opposes Bundling

Bundling would severely compromise both the quality and availability of home health care, and may actually drive up Medicare costs.

Basing post-hospital payments on DRGs is completely inappropriate. DRGs are incapable of predicting the need for or cost of home health care after a hospitalization. The post-acute care needs of a patient can be completely different from the reason for hospital admission. Home care payments based on DRG rates would simply not match patient needs.

Bundling would require hospitals to be responsible for care provided outside of the hospital setting, and requires them to become fiscal intermediaries, in some respects. Under this proposal, hospitals would be required to determine how much non-hospital care a patient needs and the best ways to provide that care. Hospitals would make decisions about a patient's continuing care needs, as well as the appropriateness and quality of care. Hospitals should not be held liable for these decisions.

Bundling would vastly increase the administrative burden on the health care system, driving costs up in non-patient care areas. It would require multiple payment

systems for home care—one for post-hospital patients and one for patients entering home care from the community. It would also require home care agencies to bill any number of hospitals for the care they provide to post-hospital patients, rather than using the current single-billing system under which agencies send all bills to their regional intermediary.

This two-track system will also result in tremendously uneven coverage decisions for patients with the same care needs. In the 1980's, coverage determinations among the different fiscal intermediaries were so great that HCFA moved to the current system of using 10 regional intermediaries as a way to ensure greater uniformity in coverage decisions. Bundling will fracture this system and put in place a system under which every hospital will interpret and apply coverage rules differently. Administrative nightmares would also be created for individuals who choose to receive their hospital care at nationally recognized institutions, but return home for their needed post-hospital home care. Increasingly, people are opting to undergo surgery or receive other hospital care at well-known hospitals, often flying to different parts of the country to receive the best possible care for their conditions. In these circumstances, bundling would require hospitals to monitor and make coverage and quality decisions about home care that is being delivered many miles away.

For these reasons, we urge you to vigorously oppose any effort to bundle home health care payments into hospital DRG rates.

NAHC Urges Enactment of PPS for Home Care

We propose the implementation of a per-episode prospective payment system (PPS) for home health care. PPS would be one way to create incentives for cost-effective utilization management. Under a per-episode PPS model, providers would receive a single payment when a patient is admitted that would cover the entire episode of care rather than paying for individual visits when they occur. In this system, providers would have an incentive to manage utilization in the most cost-effective manner.

The development of a per-episode PPS for home care has long been delayed by the absence of an adequate method to accurately adjust reimbursement to reflect the severity of the patient's medical condition, degree of functional impairment, caregiver availability, and other critical issues. NAHC proposes that a good case-mix adjustor be developed and tested by the Secretary of the Department of Health and Human Services within two years, and that a per episode PPS be put in place for home care immediately thereafter.

If a case-mix adjustor is still not ready after two years, we would propose that an interim prospective payment system be put in place, which sets per visit rates with a per episode cap, while work on the case mix-adjustor is completed. This interim plan would encourage efficiency and appropriate utilization by giving providers the opportunity to share in the savings under both the per-visit rate and episode targets. We would be concerned about moving to this interim plan too quickly since it would be an untested system. With changing financial incentives, some high cost patients may find it difficult to obtain care without an adequate case-mix adjustor. If this interim proposal were implemented, both provider and patient safeguards must be included.

While we are concerned about moving to a prospective payment system too quickly, we feel strongly that progress in moving the home care benefit into a prospective payment system must go forward and that a per-episode prospective payment system for home care is far more acceptable than proposals that have been advanced to bundle home care payments into the hospital DRG rates. The industry has been working to come to a consensus on a unified PPS plan for home health.

At the same time that the Committee is looking for ways to reduce growth in the Medicare home care benefit, we urge you to consider including in the reconciliation bill a number of proposals that would reduce unneeded regulations, increase efficiency, and streamline the Medicare home health benefit.

Include hospital-based agencies in the cost limits data base

Approximately one-quarter of the home care agencies in the U.S. are hospital based. Currently, both freestanding and hospital-based home health agencies are reimbursed for reasonable costs they incur in caring for Medicare beneficiaries up to certain limits, known as cost limits, which are set at 112 percent of the mean costs that freestanding agencies only incur in providing covered services.

Prior to 1993, hospital-based agencies received an add-on to the cost limits because of their higher administrative and general costs. OBRA93 eliminated the hospital based add on, but did not mandate that HCFA include these agencies' cost into the data base used to determine the average cost of providing home health services.

As a result, both freestanding and hospital bases home health agencies are reimbursed under cost limits that use data from freestanding agencies only.

Congress should require HCFA to combine the costs incurred by hospital based agencies with those of freestanding agencies when calculating the cost limits. Not including all agencies' costs leaves one-quarter of all agencies unaccounted for in assessing the reasonableness of home health costs.

Permanently extend the waiver of liability for home health agencies, hospices, and skilled nursing facilities

The Medicare waiver of liability, which provides a safety-zone for home care, hospice and skilled nursing providers and patients, is scheduled to expire on December 31, 1995. The waiver of liability was created by Congress in 1972 to protect Medicare beneficiaries who are later determined to be ineligible or the services are later determined not to be covered. This cushion for error was created by Congress to encourage providers to render services to Medicare beneficiaries.

In 1972, the Health Care Financing Administration (HCFA) created a presumptive status for providers whereby the providers were presumed to have acted in good faith if they demonstrated a reasonable knowledge of coverage standards in their submission of bills.

In the home health setting and for hospices, in order for an agency to be compensated under the waiver presumption, its overall denial of claims rate must be less than 2.5% of the Medicare services provided. For skilled nursing facilities, the denial of claims rate must be less than 5%. Any home health agency, hospice or skilled nursing facility that exceed these limits is not reimbursed under waiver regardless of whether it accepted beneficiaries and acted in good faith. This requirement forces providers to use due diligence in determining eligibility coverage. If the waiver expires, HCFA would make all coverage determinations on a case-by-case basis.

Without this buffer, providers would be compelled not to provide services under the Medicare program whenever there is a question of Medicare coverage. The result would be a chilling effect under which elderly and disabled individuals who might otherwise receive Medicare home health, hospice or skilled nursing services would have to pay for their care out-of-pocket or through private insurance.

Case-by-case review would also put an inordinate burden on many beneficiaries who would have to appeal denials and prove that the care in question should be covered.

This change would come at a time when more beneficiaries are in need of home care, hospice and skilled nursing services than ever before.

Congress should make permanent the waiver of liability for home health care and hospice agencies and for skilled nursing facilities in this year's reconciliation bill. Without this provision, the availability of Medicare home care, hospice and skilled nursing services may be severely compromised for many individuals in need of this care.

Provide Access to Medicare HMO Enrollment Information to Home Health Providers

Medicare will not reimburse home health agencies for care provided to Medicare HMO enrollees , even though home health agencies are not told when a patient joined an HMO. In these cases, home health agencies are not paid for care they provide in good faith.

Despite the fact that the Health Care Financing Administration (HCFA) has implemented a nationwide data base known as the Common Working File (CWF) which contains the necessary information to determine the enrollment status of Medicare beneficiary, there is often significant lag time between when the beneficiary enrolls in a Medicare HMO and the entering of this information on the CWF database. Moreover, Medicare HMO enrollees often fail to fully understand that HMO enrollment and means they cannot go to any agency they choose.

To resolve this issue Congress should:

- Allow access to beneficiary enrollment information for Medicare-certified home health agencies which provide assurances that the patient authorization is on file with the agency;
- Establish a "hold harmless" provision under the Medicare Act to protect providers who in good faith provide care to HMO members and others not enrolled in the fee-for-service Medicare program; and
- Require HMOs to inquire about health services their enrollees are receiving from other providers and to send those providers notification of HMO enrollment.

As Congress provides more incentives for Medicare beneficiaries to enroll in Medicare HMOs, the need for timely enrollment status information becomes greater. De-

spite providers' best efforts at discovering HMO enrollment, information available from patients and families is frequently inadequate and unreliable, thereby subjecting home health agencies to significant financial losses. In absence of timely HMO enrollment information, home health agencies should not be denied payment for care provided before they were informed of the patient's HMO enrollment.

Make Medicare Regulations Apply Only to Medicare Reimbursed Care

Medicare certified home health agencies have to comply with Medicare regulations for all their patients, even non-Medicare, private paying individuals. Included in these regulations is the requirement that a written plan of care be established and periodically reviewed by a physician and that agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.

The plan of care must include the patient's mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other factors.

This means that a 30-year-old auto accident victim who wants bath services from a home health agency aide while he recuperates would need a physician's verbal approval before care could begin, followed by a detailed plan of care signed by the physician. Or, that normal new (mother and baby cannot have home visits for assessment and teaching routine post-partum and newborn care without a physician's order and detailed plan of care, even though Medicare would not be paying for either of these individuals' care.

Regulations requiring that care be physician certified for non-Medicare paying patients is an unnecessary regulatory burden. In most instances, such an extensive care plan and physician certification for non-Medicare paying patients is not needed, especially if the patient is only seeking non-skilled or health promotion services. Moreover, nurses are qualified and authorized under state licensure laws and practice acts to order and supervise the provision of unskilled services and to carry out health promotion and teaching activities without the orders of a physician.

We look forward to working with the Committee on these important issues.

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